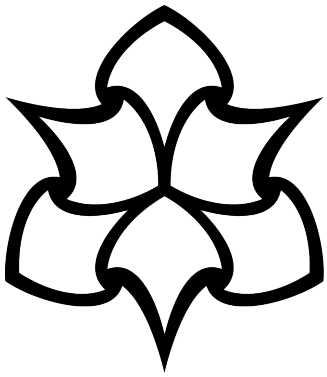

GATEWAY TO HEALTH: PROMOTING THE PHYSICAL AND PSYCHOSOCIAL WELLBEING OF OLDER ADULTS AND PEOPLE WITH LONG-TERM CONDITIONS

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ABSTRACT

The ageing population and predicted increase in the number of people with long-term conditions (LTCs) presents a challenge to healthcare systems when faced with demands to provide more cost-effective and sustainable services. Optimising citizens' health and wellbeing (HWB) could offer an efficient way to provide holistic care; however, it is not clear as to how to achieve this. This thesis demonstrates how my publications have helped to contribute to knowledge within the HWB arena for older adults and people with LTCs, and, specifically, to gain more understanding of their physical and psychosocial health needs and models of care that can promote their HWB. To offer context to these publications, this thesis provides a critical review of the relevant theory. This includes an appraisal of healthcare policy to highlight the issues faced by current health services, drivers for change and approaches to models of care. The concept of HWB has also been deliberated including a critical evaluation of its role in relation to healthy ageing and the wellbeing agenda.

Six publications are contained within this thesis and, as a collective, reflect a mixed methods research design as they involve interviews, a focus group and surveys. The final publication, a theoretical paper, is an amalgamation of all the research findings discussed within the context of a critical review of the literature and linked explicitly to the physiotherapist's role in long-term condition management. The findings of the publications are from insights gained from the perspectives of people with LTCs, though, mainly from those with neuromuscular disorders and mental ill-health, as well as older adults.

The publications' findings demonstrate the capacity of voluntary, community and social enterprises (VCSE) to provide integrated care that meets the holistic needs of those who access them whilst, potentially, addressing the social determinants of health. They also highlight the necessity for supporting people with LTCs to improve their life circumstances through their own personal empowerment. This includes the ability to facilitate their readiness to take on the responsibility with partnership working between the individual and the healthcare worker and psychological support when needed being identified as key. Developing the person's social skills and aptitude to build interdependent relationships have been determined as the ultimate goal to enhance capacity for community engagement and further access to HWB resources. The publications' findings also show that capitalising on the power of social networks to foster older adults' adherence to community physical activity (PA) groups may promote HWB and, thus, the ability to age healthily. It was also found that if older adults become embedded within the PA group's network they could shape the environment to fulfil their own needs. In addition, the findings advocate the necessity for a transformation in physiotherapy practice including enhancing the physiotherapists' role as health promoters. It is proposed that only by doing so; they can remain contemporary and continue to support the optimisation of the HWB of older adults and people with LTCs.

Further to the publications, this thesis comprises a critical commentary that includes how VCSE can support healthcare services by promoting the HWB of people with LTCs and older adults. Finally, this thesis culminates in a critical discussion of the implications, for practice and policy, of the findings from my publications, with recommendations for further research.

ACKNOWLEDGEMENTS

I would like to give a big thank you to my supervisor Dr Gillian Yeowell for providing me with encouragement when needed and constructive feedback to enhance my work. Also to Professor Francis Fatoye and Dr Kathryn Heathcote who both shared with me their words of wisdom.

To my co-collaborators and all the participants who took the time to take part in my research without whom, these publications would not have been possible.

Finally, to my family and friends whom, in your own unique ways, have supported me along this journey and made me truly thankful for having you in my life.

GLOSSARY

BAME	black, Asian and minority ethnic
CSP	Chartered Society of Physiotherapy
DH	Department of Health
5YFV	Five-Year Forward View
HWB	health and wellbeing
LTCs	long-term conditions
NCDs	non-communicable diseases
NHS	National Health Service
NMC	Neuromuscular Centre
NMD	neuromuscular disorders and related muscular dystrophies
PA	physical activity
PHE	Public Health England
SCIE	Social Care Institute for Excellence
SF-36	Short Form Health Survey
SDGs	sustainable development goals
SDH	social determinants of health
UN	United Nations
VCSE	voluntary community and social enterprises
WBWs	wellbeing workers
WCPT	World Confederation for Physical Therapy
WBS	Wellbeing Service
WHO	World Health Organization
YLDs	years lived with disability

STRUCTURE OF THESIS

This PhD by publication is based on six publications that I have been sole or first author. There are six chapters; the introduction and literature review, four chapters centred around the publications and a discussion with a conclusion. Each of the four main chapters follows the same format:

- Introduction to Chapter
- Introduction
- Background to publication(s)
- Research findings and impact
- Published article
- Critical commentary of publication
- Introduction
- Critical commentary
- In Summary
- Lessons leant
- Chapter Summary

SUMMARY OF PUBLICATIONS

PUBLICATION	IMPACT	INVOLVEMENT AND CONTRIBUTION
Hartley et al., (2011) 'Experiences of attendance at a neuromuscular centre: perceptions of adults with neuromuscular disorders.' Journal: **Disability and Rehabilitation**	1.80	Identified the study aim and developed the methodology. Liaised with the Neuromuscular Centre in order to gain access to the participants and arrange the interviews. Undertook all the interviews, data analysis, and inputted information onto NVivo. Wrote the final article. Co-authors provided peer review and feedback throughout the process. **CONTRIBUTION 85%**
Hartley and Stockley (2013) 'It's more than just physical therapy: reported utilization of physiotherapy services for adults with neuromuscular disorders attending a specialist centre.' Journal: **Disability and Rehabilitation**,	1.80	Seeded the initial idea for the research project and took the lead in developing the methodology, the design of the questionnaire and data analysis. Liaised with the Neuromuscular Centre in order to gain access to the participants and collect completed questionnaires. Inputted data onto SPSS and analysed with co-author. Main contributor in writing the final paper. **CONTRIBUTION 75%**
Hartley and Yeowell (2015) 'Older adults' perceptions of adherence to community physical activity groups'. Journal: **Ageing and Society**	1.39	Collaborated with the co-author to develop a research question and methodology for the research. Liaised with the gatekeeper from the local government in order to gain access to the physical activity groups and participants for the focus group interviews. Undertook the focus group interviews. Analysed the data with the co-author. Main contributor in writing the article **CONTRIBUTION 65%**
Hartley and Stockley (2016) 'Collaborative goal setting with adults attending physiotherapy at a specialist neuromuscular centre: is it always appropriate? A cross-sectional survey.' Journal: **Physiotherapy**	3.01	Developed the idea for the paper and the research question. Main contributor in writing the article, which used some original data from Hartley and Stockley (2013). **CONTRIBUTION 90%**
Hartley (2017) 'Service users' perceptions of an outreach wellbeing service: A social enterprise for promoting mental health'. Journal: **Community Mental Health Journal**	1.15	Seeded and developed the research question and methodology. Developed a questionnaire. Liaised with the social enterprise in order to gain access to the participants and collect data. Set up SPSS and inputted data into the system. Analysed the data, including the statistical testing of the outcome measures. Wrote the final article. Had peer reviews with research colleagues **CONTRIBUTION 100%**
Hartley (2018) 'Re-imagining the role of the physiotherapist when managing people with long-term conditions'. Journal: **Physiotherapy Theory and Practice.**	1.129	Seeded original idea and developed the research aim and the critical stance to undertake this theoretical paper. Reviewed all literature and wrote the paper. Conducted a peer review with a research colleague **CONTRIBUTION 100%**

1 BACKGROUND AND CONTEXT

1.1 INTRODUCTION

Long-term conditions (LTCs) or non-communicable diseases (NCDs) are chronic disorders that tend to be progressive in nature with no cure and thus, require ongoing management (Department of Health (DH), 2012; Global Burden of Disease Collaborators (GBD), 2016a). Most common conditions include cardiovascular and respiratory diseases, cancer and diabetes (Bloom et al., 2011). The global economic burden, including loss of productivity and healthcare expenditure for these four NCDs and mental health conditions, is predicted to cost more than $47 trillion (£36 trillion) over the next 20 years (Bloom et al., 2011). In 2016, LTCs accounted for approximately 648·6 million (80.6%) of years lived with disability (YLDs) globally (GBD, 2017a) and calculated to be 72.3% of total world mortality (GBD, 2017b), thus becoming the leading cause of death (World Health Organisation (WHO), 2018a). Due to the prediction that LTCs will cause 70 million fatalities globally by 2030 (WHO, 2013a), LTCs are increasingly, becoming an international concern (Bloom et al., 2011). In England alone, 70% of total expenditure on health and social care is spent on LTCs, and with the estimated increase in numbers of people in England with LTCs from 15 to 18 million by 2025 (House of Commons Health Committee, 2014), it is clear that costs are becoming financially unsustainable (World Economic Forum, 2013).

The older population is rapidly accelerating with the number of adults aged 60 years and older predicted to increase two-fold globally, from 962 million in 2017 to 2.1 billion by 2050 (United Nations (UN), 2017). People aged 80 or over are expected to triple from 127 million in 2017 to 425 million in 2050 (UN, 2017). The

prospect of having co-morbidities increases with age (Prince et al., 2015). In England, in 2015 it was estimated that 45.7% of people aged 65 and over had two or more LTCs and this is predicted to increase to 67.8% by 2035 (Kingston et al., 2018). In contrast, health services are still largely focused on single disease interventions (Banerjee, 2015; Kingston et al., 2018). Therefore, with health care expenditure expected to escalate because of morbidities associated with these conditions (Muka et al., 2015; He et al., 2016), more innovative means to provide access to cost-effective services to manage LTCs are needed.

However, most LTCs are preventable (WHO, 2013a; Allen, 2017). Many are acquired because of poor lifestyle choices including physical inactivity, unhealthy diets, alcohol abuse and smoking (GBD, 2016b). Indeed, it is claimed that these modifiable risk factors alone account for over half the disease burden of later life (Newton et al., 2015). Even as an older adult, making better lifestyle decisions can potentially extend life by moderating morbidities (Rizzuto et al., 2012). Therefore, identifying effective ways to target interventions at the population level through the promotion of health and wellbeing (HWB) could make a significant contribution to the prevention of LTCs and their progression.

1.2 LITERATURE REVIEW

1.2.1 Drivers for change

1.2.1.1 International Policy

The guiding principles of current health policy agenda, both at an international and national level, have been directed towards tackling the challenges faced due to an ageing population and the epidemic of LTCs (WHO, 2013a). WHO's Global NCD Action Plan 2013-2020 was a key policy initiative as it provided a blueprint to addressing LTCs. It comprised nine voluntary global goals including the attainment of a 25% relative reduction in risk of premature mortality from the four major LTCs globally by 2025 (WHO, 2013a). The policy was developed to promote a collective undertaking by Governments and Heads of States to reduce the global burden of LTCs (WHO, 2013a). Setting global targets in this way can be seen as an attempt by WHO to influence the focus of Governments' health policies, as national intentions towards the NCD's agenda would need to be established to support the achievement of these global aims. However, this policy had been slow in coming as NCDs were by this time becoming well-established (WHO, 2011). Certainly, it was not until 2015 when the UN included NCD targets within their sustainable development goals (SDGs) that adoption of NCD policy become more of a national responsibility (Allen, 2017). The aim of this SDG was to reduce, by one third, premature mortality from NCDs by 2030, through prevention and treatment and the promotion of mental health and wellbeing (UN, 2015). This is the first time that a UN sustainability goal had been directed towards NCDs and thus demonstrates the increasing concern globally with LTCs. As sustainability goals are developed based on commitments made by World

Leaders from UN states at the UN Assembly (UN, 2015), it is a pivotal moment for the NCD agenda as it acknowledges international Governments' acceptance of national accountability to LTCs. Included within this policy was the agreement by World Leaders of the need to strengthen national health care systems and to make health promotion and prevention key to the global eradication of NCDs (UN, 2015). Momentum for addressing NCDs has since continued to be built through the endorsement made by Governments and Heads of States to the Montevideo roadmap 2018-2030 (WHO, 2017a). In this policy, Government Leaders re-asserted their commitment to a coordinated effort to achieving the UN target of reducing premature mortality from NCDs including financing and strengthening national healthcare systems (WHO, 2017a). This demonstration of international unity for decreasing the burden of LTCs highlights the need for prioritising national policies that are focused on achieving goals to address LTCs (Masic, 2018).

1.2.1.2 National Policy

United Kingdom healthcare policy, although influenced by their commitment to the global agenda, has also been shaped by other local factors. Certainly, increasing financial pressures on the healthcare system have become one of the predominant health policy drivers (Stuckler et al., 2017). The rise in the number of older adults and people with LTCs coupled with the technological advances have led to treatments becoming more expensive (Ham, 2018). Rising public expectations about their healthcare have also led to more demands on health services (Maguire et al., 2016) and years of austerity has resulted in cuts in provision (Stuckler et al., 2017). This has led to the prediction that the NHS will

have a funding gap of £30 billion by 2020/21 unless there are efficiency savings of £22 billion (NHS England (NHSE), 2014). However, due to the high level of deficits that are already occurring in NHS trusts, this could be deemed as unrealistic (Gainsbury, 2017). Nevertheless, all these factors are influencing national health policy doctrine, as there is the realisation that the healthcare system in its present form is becoming increasing unsustainable (Ham, 2018).

The Five-Year Forward View (5YFV) published by NHSE in 2014 is a fundamental document, as its aim is to transform the healthcare system (NHSE, 2014). It sets out a future vision of an NHS that is focused on improving population health and reducing health care disparities through more efficient and effective ways of working (NHSE, 2014). To achieve this, the emphasis is placed on developing new models of care that are directed towards public health promotion and prevention, patient-centred care through the empowerment of individuals and communities and cost-effective provision (NHSE, 2014). To inspire action, it can be deemed that policies need to be realistic and attainable so that they can be translated into practice and have a beneficial effect on people's lives (Frith, 2015). The distinction of the 5YFV from other policies is that it does not set out a rigid, master plan to follow. Instead, it considers models of care that are adaptable in design so that services can be put in place that support the needs of diverse local populations (Ham et al., 2017). Being less prescriptive could, therefore, help to make the policy initiatives more workable in different contexts and settings as it can be tailored to communities and the needs of its population. Having a flexible approach to care could enhance the prospect of providing interventions that more effectively meet the local population's requirements and, thus, improve community health outcomes (Corbett-Nolan et

al., 2018). Nevertheless, this will only be realised if efficient strategies are put in place that reach out to all groups of people within that community, including minority ethnic groups and rarer LTCs. Otherwise, disparities will continue, leading to greater health inequities (Cook et al., 2015).

1.2.2 Models of Care

1.2.2.1 Integrated Care

A key feature of new models of healthcare has been identified as the need for them to be designed around the principles of integration. There are, though, many different definitions and approaches to integrated care, which makes its application challenging (Goodwin et al., 2013). However, it can be characterised to be the coordination of care around the physical, mental and social needs of the patient (WHO, 2016a). This can include across primary, secondary and tertiary care as well as health and social care (Nolte and Pitchforth, 2014). Integrating care can, therefore, help to break down barriers between health and social care and prevent the fragmentation of services that often prevails within healthcare (Watson, 2012). Fragmentation of care often leads to inefficient and poor quality service as many people fall through the gaps, become lost in the system, and therefore do not receive the care that they need (de Carvalho et al., 2017). Conversely, integrating provision around the needs of the patient can reduce duplication of care and, hence, offer a more cost-effective approach to improving health outcomes (Goodwin et al., 2013). Therefore, integrated care can be especially beneficial for older adults and people with LTCs, as their needs are often multiplex and expensive, often requiring input from a variety of providers and services in different settings (de Carvalho et al., 2017). Being more

concerned with the holistic needs of the patient, integrated care can also facilitate more consideration of peoples' mental wellbeing, thus supporting the drive both internationally and nationally for parity of esteem between physical and mental health (WHO, 2013b). This is particularly pertinent for people with LTCs as they are up to three times more likely to have a mental health problem than the larger population (Naylor et al., 2012) and having mental ill-health increases the prospects of developing a physical LTC (Barnett et al., 2012). It is also a concern for older adults as although the chance of having mental health problems is no greater than younger people, disclosure, diagnosing and hence management has been found to be less likely to occur in this age group (Mueller et al., 2017). Therefore, integrated care that provides better access to therapies that promote mental health could offer more effective support for people with LTCs and older adults (NHSE, 2017), thus leading to improved health outcomes (Ham and Curry, 2011).

Even though there have been a number of health policies promoting integrated care, its evolution has been slow (Humphries, 2015). In 2005, elements of integration were included in the National Service Frameworks (NSF) for people with LTCs with the aim of improving standards of care for these individuals (DH, 2005). The Framework was based on eleven quality requirements with the expectation that they would be fully established within health services by 2015 (DH, 2005). Neurological conditions were, however, the focus of the evidence that supported its implementation (DH, 2005). Therefore, although concepts of the framework could be said to be relevant to all people with LTCs (Hainsworth, 2005), incorporating findings from studies specific to other types of LTCs would likely enhance its effectiveness. Since the inception of this NSF, additional

research has been undertaken that demonstrates the potential contribution that this NSF could make in enhancing the quality of practice when managing people with LTCs. Although these findings, likewise, are based on neurological conditions they also include insights from people with neuromuscular disorders (Dawes et al., 2010).

A range of LTCs, including mental health, was the focus of a King's Fund policy initiative in 2010 that further promoted the need for integrated care in LTC management (Goodwin et al., 2010). With the subsequent introduction of the 'House of Care', a framework for implementing person-centred integrated care was provided (Coulter et al., 2013). Focused towards developing collaborative partnerships with their patients, it offered a practical model that healthcare professionals could follow (Coulter et al., 2013), hence, potentially, helping to facilitate its adoption.

To foster more integrated care for older adults, the integrated care for older people (ICOPE) framework was established by WHO (WHO, 2017b). It promotes models of care that incorporate a community-based, multi-sectoral approach around the needs of the older person (WHO, 2017b; Briggs et al., 2018). Specific elements of care that are deemed to be important are comprehensive assessments, sharing of care plans across providers, and goals that promote the intrinsic capacity of older people and their functional ability (WHO, 2017b; Briggs et al., 2018). Nevertheless, there is insufficient evidence of best practice initiatives for community-based integrated care that is comprehensive in its support of the holistic needs of older adults (de Carvalho et al., 2017; Briggs et al., 2018). Therefore, more research on the practical application of these models of care needs to be undertaken to further demonstrate their effectiveness.

Having integrated care systems embedded throughout England by 2021 is just one of the aspirations of the NHS Long Term Plan (NHSE, 2019). It builds on the foundations of the 5YFV by progressing models of integrated care, with primary care networks being one example of this (NHSE, 2019). Primary care networks are created through partnership working between general practices and across multi-sector organisations and health, social and community care (NHSE, 2019). Offering the opportunity for the co-ordination of physical, mental and social provision in this way will support the ICOPE and WHO's drive towards community-based holistic care models for older adults (WHO, 2017). Having access to a number of primary and community services and community-based resources in an integrated way could also support older adults to live more independent, healthier lives in their community (de Carvalho et al., 2017). Additionally, they could be particularly beneficial for older adults and people with LTCs who have complex health and social needs (Charles, 2019). However, their success relies on the creation of productive alliances and access to an appropriate workforce that has the skills to work in this manner (Baird, 2019; Charles et al., 2019). Therefore, time will be needed to develop these partnerships and adequate funding to replenish the shortfall in both workforce numbers and budgets for education, training and development of staff (Charles, 2019). Although the government pledge of an extra £4.5 billion to develop primary and community-based healthcare (NHSE, 2019) will go some way to support initiatives in this area, it will not be clear, until the Spending Review is published later in 2019, as to whether financial backing towards workforce training and education materialises (Charles et al., 2019).

1.2.2.2 Voluntary, community and social enterprise sector

The voluntary, community and social enterprise sector (VCSE) are organisations that often function outside of formal healthcare. These can include small local voluntary and community groups, charities and social enterprises (DH et al., 2016). As they are created because of community needs that are not being met and to address social problems (Macaulay et al., 2018a), they can help to reduce disparities by filling a gap in provision as well as targeting the social determinants of health (Dayson et al., 2016). Additionally, by utilising the support of people from groups whose needs they aim to meet as well as volunteers, they can offer cost-effective initiatives that are more reflective of peoples' needs (Fox, 2017). Therefore, they could be considered to be more person-centred and, hence, potentially more effective as interventions can be tailored to their requirements (The Health Foundation, 2016). VCSE could, thus, make a valuable contribution to promoting the HWB of older adults and people with LTCs as they could support their health and social care needs besides fostering positive health behaviours (Roy et al., 2017). However, the value of VCSE for supporting HWB is often not realised by commissioners and, hence, their services not always obtained (Baird et al., 2018). This may be because their social goals and outcomes are often not aligned with health services who are still focused towards medical management and, therefore, value measurements that reflect this (Brüssow, 2013; Roy et al., 2013). The recent publication of the NHS Long Term Plan and its championing of community-based multi-sectoral partnerships may, though, promote more consideration of VCSE collaborations in the future (NHSE, 2019). Nevertheless, additional research and further evidence that demonstrates the potential of

VCSE, including their ability to work effectively with other healthcare services, will further support their procurement.

1.2.3 Health and wellbeing agenda

1.2.3.1 Defining health and wellbeing

When, in 1946, WHO redefined health to ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity’ (WHO, 1946:1), it was seen as revolutionary. This was because for the first time it highlighted the holistic nature of health (Badash et al., 2017). However, this definition is still focused on illness and its eradication as, when it was first coined, acute infectious diseases were the major cause of mortality (Masic, 2018). Yet, today, as LTCs have become most prevalent and expected to rise due to unhealthy lifestyle choices, health promotion and prevention are now becoming more significant than just treatment of symptoms (Ham et al., 2012). Additionally, having to be in ‘a complete state of physical, mental and social wellbeing’ means, for people with LTCs and many older adults, being healthy is impossible to attain (Smith, 2008). Therefore, in a modern healthcare system, this characterisation of health seems rather lacking.

More recently, there has been an increase in popularity in wellbeing as a more contemporary notion of health. This is because it is more concerned with what makes people well and, therefore, shifts focus away from illness (De Foe et al., 2014). However, helping people to attain positive wellbeing can be challenging as it has been defined in so many different ways (Dodge et al., 2012). Commonly, though, there are two schools of thought: hedonistic and eudemonic wellbeing. Hedonism is based on the view that pleasure seeking and pain avoidance leads

to happiness, whereas eudemonism is concerned with having a purposive life and being able to actualisation one's own potential (De Foe et al., 2014; Steptoe et al., 2015). However, there are also other interpretations of wellbeing including 'feeling good and functioning well' (De Foe et al., 2014:6) and having a good quality of life (Mitchell et al., 2005). Wellbeing, therefore, becomes a personal perception that is based on peoples' own experiences of what being well means to them (White, 2008). Thus, this would seem more relevant for older adults and people with LTCs as it provides the opportunity for a positive health gain no matter what their life circumstances are (White, 2008). Additionally, by working with individuals to identify what is important for their wellbeing, it facilitates more collaborative involvement in their own care and therefore offers a more person-centred and holistic approach to health (The Health Foundation, 2016).

1.2.3.2 Healthy ageing

The concept of wellbeing is also central to the healthy ageing agenda. WHO defines healthy ageing as "the process of developing and maintaining the functional ability that enables well-being in older age" (WHO, 2015:28). There are, though, critics of wellbeing. Many claim it to be a political agenda to mitigate austerity by inciting people to become involved in their own health and, therefore, lessen the healthcare support that would otherwise be needed (White, 2010). It has also been avowed that it could put increasing demands on people to feel positive and well, which might lead to more alienation of people who feel negative and unwell (White, 2017). However, the healthy ageing agenda not only recognises the influence of the older adult's intrinsic capacity (physical and psychosocial aptitude) on their ability to be healthy, but also understands the

importance of the wider determinants of health, particularly the environment (the context in which their life takes place) (WHO, 2015). Consequently, it is concerned with supporting older people to live a good quality and safe life through the development of community capacity and the creation of environments that help them to achieve this (WHO, 2015). Therefore, with regard to peoples' wellbeing, rather than it being an individual pursuit where the demands become a personal burden, responsibility for health becomes a shared endeavour across the community where support is available if they wish to access it (White, 2017). Additionally, by taking into consideration the wider determinants of health, it is more health promotion and prevention focused. This seems pertinent for older adults, as morbidities are common, and promotion and prevention of health can help to reduce the impact of these conditions or avert them from occurring (Sims, 2017).

There is no doubt that incorporating wellbeing into the health arena can be challenging, as it is difficult to define and hence implement. However, if ways to accomplish this can be found it can provide opportunities for older adults and people with LTCs to live a quality life in which they can learn to flourish, despite adversity (Pattison and Edgar, 2016). In an endeavour to explore this further, the intention of my research, therefore, has been to gain an insight into the experiences of older adults and people with LTCs when attending VCSE. The purpose has been to gain more understanding of innovative models of care that can promote their HWB.

1.3 AIMS

To achieve this, the main aims of my research have been threefold:

1. To gain an understanding of models of care that could enhance the HWB of people with long-term conditions, including neuromuscular disorders and mental ill-health, and support the healthy ageing of older adults.
2. To investigate the role of VCSE in fostering the HWB of people with LTCs
3. To explore community initiatives that promote healthy ageing and cultivate positive HWB in older adults.

2 SOCIAL ENTERPRISES

This chapter aims to promote the case for the employment of social enterprises in LTC management. It will present two publications (1 and 2) that demonstrate the potential of a social enterprise as an innovative model to enhance the healthcare needs of people with neuromuscular disorders and related muscular dystrophies (NMD).

2.1 INTRODUCTION

Health Services are failing to prevent inequities in health and social care provision. One reason for this is that there is a lack of effective, integrated services to support people with LTCs, leading to a postcode lottery for accessing specialist care (Goodwin et al., 2013). This is a particular issue for rarer LTCs, such as people with NMD. Due to their complexity and the lack of clinicians with expertise in this area, many individuals receive poor quality or no care at all (Hill and Philips, 2006). In an endeavour to address these healthcare disparities, the UK Government has championed the involvement of social enterprises (Roy et al., 2013). This is because social enterprises have the ethos of a public health service with the inventiveness and productivity of a business and, therefore, their utilisation is seen as an opportunity to improve the efficiency of healthcare provision (Frith, 2014).

2.2 PUBLICATION 1

2.2.1 Background

Hartley et al., (2011) came to fruition following an opportunity I received to undertake research at a neuromuscular Centre (NMC). At this time, the NMC was the only known social enterprise in the UK and Europe that offered holistic services for people with NMD. Therefore, potentially, it offered the chance to obtain an insight into a novel model for service provision. There was also limited research on adults with NMD, particularly of their experiences of service provision. Gaining clients' views in this way would help to enhance the impact of any proposed changes to service provision. This is because as experts by experience of NMD, clients could offer unique perspectives that otherwise may have not been considered (Kelley et al., 2016). This will enhance the ability to provide a more person-centred approach as future interventions can be tailored to their holistic needs, thus promoting more effective care (The Health Foundation, 2016).

2.2.2 Research findings and impact

The aim of publication 1 was to gain an understanding of the NMC through the lived experiences of adults who used this service. This was in order to develop knowledge of the value of the NMC as a service provider. The findings highlighted that having access to a number of specialist services at one site that offered holistic care was particularly important to service users. It also revealed that engaging with other people who had a similar condition assisted service users to become more self-aware and accepting of their situation. This research has both international and national importance as, for the first time, it highlights a

contemporary model of care for people with NMD, but also potentially for other LTCs, to promote the optimisation of their healthcare provision and foster better health outcomes. Exploiting social enterprises, in this way, could also have an economic impact as supporting the holistic needs of service users would likely reduce their requirements for NHS treatment and, hence, future costs (Dayson et al., 2016). Additionally, as this model fostered employment opportunities for service users, both they and the community could benefit from increased revenue (Jackson, 2011). The social impact of this publication is that it provides insights into the challenges that people with NMD face in their daily lives and their perceived marginalisation within society. Highlighting their plight, in this way, could foster action that promotes their inclusivity into society and, thus, helps to reduce their feelings of disparity.

2.2.3 Published article 1

Hartley, S., Goodwin, P. and Goldbart, J. (2011) 'Experiences of attendance at a neuromuscular centre: perceptions of adults with neuromuscular disorders.' *Disability and Rehabilitation*, 33(12) pp. 1022–1032.

Ethical approval: Manchester Metropolitan University Faculty of Health, Psychology and Social Care Ethics Committee (Reference no 0807)

Link to publication - https://doi.org/10.3109/09638288.2012.691940

2.3 PUBLICATION 2

2.2.4 Background

Hartley and Stockley (2013) built on the findings from Hartley et al., (2011). One of the benefits of attending the NMC, highlighted by service users, was the ability to gain regular access to specialist physiotherapy (Hartley et al., 2011). At this time, although physiotherapy had been recognised as an important aspect of management for people with NMC, there was controversy as to what constituted an optimal physiotherapy intervention (Cup et al., 2007). These decisions about physiotherapy input also lacked insight from people with NMD as to what they perceived as the most advantageous for supporting their needs. Therefore, this provided me with an opportunity to gain service users' views about what they felt was important when providing physiotherapy and what they regarded as the optimum treatment. Again, this could help in tailoring physiotherapy to their needs and thus provide more effective service provision. The aim of the study was to describe and explore the utilisation of physiotherapy at the NMC in order to gain further insights into service users' perceptions of the physiotherapy service provision.

2.2.5 Research findings and impact

The findings reaffirmed the importance of holistic care provision to service users. It also highlighted the variability in perceptions of what constitutes the optimum amount of physiotherapy treatment for adults with NMD. The importance of this publication both internationally and nationally is that it demonstrates the need for personalised service provision for people with NMD, thus questioning the supposition from previous research that suggests a more standardised approach

(Cup et al., 2007). It also proposes how the challenges faced when trying to balance access to appropriate interventions without facilitating over dependency on specialist care can be mitigated by supporting individuals to become more self-autonomous (Hartley and Stockley, 2013). Providing more effective interventions and developing the resourcefulness of people with NMD has a social impact as it helps to improve their quality of life and fosters greater health equity. Both publications also support a change in policy that promotes more equity in healthcare provision for people with rare LTCs.

2.2.6 Published article 2

Hartley, S. and Stockley, R. (2013) 'It's more than just physical therapy: reported utilization of physiotherapy services for adults with neuromuscular disorders attending a specialist centre.' *Disability and Rehabilitation*, 35(4) pp. 282-290.

Ethical approval: Manchester Metropolitan University, Department of Exercise and Sports Science academic Ethics Committee (IPS approval code 11.02.10(i)).

Link to publication - https://doi.org/10.3109/09638288.2012.691940

CRITICAL COMMENTARY OF PUBLICATIONS 1 AND 2

2.2.7 Introduction

Social enterprises are increasingly being seen as key partners within the healthcare system as they can offer specialist services for people with health and social care needs in the community and support public health initiatives (Roy et al., 2017). Often situated in the centre of their neighbourhood, social enterprises can provide a vital link to the local people (Kidd and McKenzie, 2014). There is no definitive consensus as to what constitutes a social enterprise as there are many models presented (Peattie and Morley, 2008). However, a defining principle is the use of business means to achieve social goals with any cash surplus being re-invested into the enterprise, or into developing the local community (Park and Wilding, 2014).

2.2.8 Critical commentary

Both publications presented have demonstrated the capacity of the Neuromuscular Centre (NMC), a social enterprise, for improving the HWB of people with NMD. The NMC, by providing individuals with access to specialist interventions that they would otherwise have been unable to obtain, helped in filling this gap in healthcare provision for people with NMD (Hartley et al., 2011; Hartley and Stockley, 2013). Additionally, by having services integrated together in one place, the NMC provided the opportunity to co-ordinate care around the biopsychosocial needs of the individual, thus enhancing its ability to provide more holistic, patient-centred care and improve health outcomes (Hartley et al., 2011; Hartley and Stockley, 2013). This is often contrary to more formalised healthcare systems where frequent fragmentation of its services, and poor communication

between different health professionals, results in comprehensive care in this way not being realised (de Carvalho et al., 2017).

One of the main issues with social enterprises, however, is that they frequently put their social values before cost-efficiency, which can lead to them becoming financially unviable (Rykaszewski et al., 2013). The NMC, however, has many different streams of funding including Clinical Commissioning Group grants and charitable donations. Its main revenue, though, is gained from its profitable design and print company (Neuromuscular Centre (NMC), 2017). Using a business model in this way to fund its endeavour will help to make it more financially sustainable (Macaulay et al., 2018b). Although the NMC is for people with NMD, potentially this could be an exemplar for offering services for other LTCs to help meet their health and social needs, thus fostering more equity in health provision (Kidd and McKenzie, 2014). This is supported by the NMC's recent accolade where it received the Queens' Award for Voluntary Service, thus demonstrating national recognition for this model of care (NMC, 2017).

However, due to the limited provision of services for NMD nationally, the NMC has a large catchment area including North West England and Wales. Therefore, if the need for its service grows it could, possibly, become unviable in the future unless satellite centres are developed in other areas of the country. Since undertaking the research at the NMC, another Centre for adults with NMD has been established in England that reflects the NMC model (Muscular Dystrophy Support Centre, nd). Although this is a move in the right direction, it seems prudent to suggest that a more radical strategy will need to be employed that supports the implementation of such service provision nationally. Otherwise, the impromptu creation of Centres in this way may, in fact, augment the postcode

lottery for accessing these services and, hence, enhance inequity in care for people with NMD (Hill and Phillips, 2006). However, gaining endorsement for any model of care could be challenging, as it is likely both its clinical and cost effectiveness will need to be demonstrated, as these are policymakers' and commissioners' main priorities (Roy et al., 2017). Certainly, finding measurable ways to prove social and economic impact is difficult, especially the benefits that are perceived by service users themselves such as improved confidence and purpose in life (Bertotti et al., 2011). It could also be said that, whilst the ability to access all services at one site was particularly valued at the NMC, issues created by providing a one-stop source for people with the same health condition also needs to be recognised. Whilst this can foster the sense of belonging to other service users, as was highlighted at the NMC, it could also enhance perceptions of marginalisation outside of the NMC (Best et al., 2014). Indeed, many of the attendees identified a disparity to other people who did not have NMD (Hartley et al., 2011). Considering more means to promote diversity at the NMC may, though, help to mitigate this. For example, a recent endeavour by the NMC is the creation of a Craft Club within the NMC building, but open to all citizens within the community including those with and without NMD (NMC, 2017). Engaging people together in this way may foster a more inclusive environment where people feel an affiliation due to their interest in crafts rather than their LTC (Hartley et al., 2011). The NMC also offers training courses that provide service users with the skills to gain employment in the wider community (Hartley et al., 2011). Identifying further opportunities to integrate service users back into their neighbourhood could also help them to feel more connected to others and engender a more socially inclusive society (Roy et al., 2017). Furthermore, being supported to

develop the capacity to participate more within the community could also be more empowering for individuals and foster more independence rather than dependency on the NMC for their own self-management (Blickem et al., 2013).

2.2.9 In summary

New ways of working are needed to provide appropriate health provision for people with LTCs. Social enterprises offer the potential to make a valuable contribution to support the HWB of people with LTCs. By reaching out to the underserved in their community, they help to reduce inequalities in health provision. Promoting more collaborations between healthcare services and social enterprises, where resources are shared, could foster more innovative approaches to healthcare that are holistic and cost-effective, thus helping to transform healthcare provision for people with LTCs.

2.3 LESSONS LEARNT

In Hartley and Stockley (2013), I included additional questions to the questionnaire that were open-ended. As I still had limited information about the physiotherapy provision, I felt I wanted to explore this further to gain more understanding of service users' expectations and satisfaction with the physiotherapy provision. Including open questions would allow me to do this but in a way that would be more client focused rather than researcher focused, as it would be their ideas and assumptions that would be presented (Wiseman et al., 2015). There are, though, issues to including these types of questions that need to be considered. Open questions are more time consuming to fill in and, therefore, may lead to fewer people choosing to engage with the questionnaire (Bowling, 2005). This may or not have been the case in my study; however, I did

attain a 78% response rate, which is acceptable for survey designs (Nulty, 2008). It has also been claimed that the respondents who answer these questions are more likely to have certain characteristics such as being more literate (Garcia et al., 2004; Riiskjær et al., 2012). Certainly, not everyone answered all the open questions. Therefore, these responses cannot be claimed to provide a full representation of all people who were involved in this study. It did, though, allow those who wanted to have more of a say, the platform to voice this when they otherwise would not have had that opportunity (Garcia et al., 2004). It also offered new insights that I would not have identified that could also provide direction for any future research in this area (O'Cathain and Thomas, 2004). Therefore, it can be contended that the open questions helped to strengthen the research by adding another perspective and reinforcing the analysis. However, potential issues with including open questions will be explored further in chapter 3.

2.4 CHAPTER SUMMARY

This chapter has demonstrated the case for utilising social enterprises to support the HWB of people with LTCs. However, as this could foster more dependency on healthcare provision, the next chapter will consider ways to foster more independency in self-care.

3 SELF-MANAGEMENT

This chapter will present two papers (3 and 4) to explore ways to develop the capacity of people with LTCs to self-manage their own HWB in order to lead lives that are more independent in their community.

3.1 INTRODUCTION

Self-management can be defined as taking responsibility for the management of one's own HWB (Kawi, 2014). It is seen as fundamental to LTC management as it can potentially improve health outcomes (Peek et al., 2016). It is also seen as a means to reduce demands on healthcare systems and, hence, utilisation costs (Panagioti et al., 2014a) as it mitigates dependency on health care professionals for improving health status (Jones et al., 2013). However, limited access to the appropriate self-management support strategies for people with LTCs or a disinclination to adhere to its practice has led to these benefits often not being realised (Kennedy et al., 2013). Therefore, it would seem that more effective strategies need to be implemented that facilitate people to self-manage (McLean et al., 2010). In the following publications, alternative ways to optimise self-management support for people with LTCs are explored.

3.2 PUBLICATION 3

3.2.1 Background

Collaborative goal setting between clinicians and patients has been increasingly seen as a key element of self-management of LTCs (Peek et al., 2016). However, putting it into practice can be challenging as there is no standardised way to undertake it and patients and clinicians often have different priorities as to what is perceived as important to achieve (Vermunt et al., 2017). This was highlighted to me whilst engaged in research at the Neuromuscular Centre (NMC). A supplementary finding of this research was that only 37% of participants had reported that they had set goals with their physiotherapists (Hartley and Stockley, 2013). I felt that this seemed worthy of further consideration as the setting of collaborative goals with their clients was deemed, by the NMC Physiotherapy Department, as their normal practice which is in contrast to my research findings. Therefore, this was a view that these findings appeared to belie. Delving deeper into this apparent disparity between the physiotherapists' and clients' beliefs of the goal-setting process would be beneficial for physiotherapy practice both internationally and nationally as collaborative goal setting is seen as a requisite for achieving professional standards (World Confederation for Physiotherapy (WCPT), 2011). Hence, more clarity on this concept would seem invaluable. The purpose, therefore, was to explore the data from the NMC, to gain more of an insight into clients' perspective of what may influence goal setting. The intention for undertaking this was to facilitate a discussion about the practice of collaborative goal setting in adults with neuromuscular disorders (NMD) in order to inform future practice.

3.2.2 Research findings and impact

This publication highlights that collaborative goal setting for people with NMD may not always be appropriate, as some patients may not have the capability or desire to share the goal-setting process. It also brings to attention the importance of nurturing the emotional health of people with NMD and the setting of goals that support psychological wellbeing, as this can influence both the ability to take part in goal setting and to be more self-regulating. Hence, goals setting can provide a valuable tool to facilitate self-management but only when used effectively.

The importance of this publication is that it questions the approach to collaborative goal setting and challenges the notion that it is always appropriate to use in patient management. It also brings to the fore the need for a reconceptualisation of the process of goal setting and a redefinition of the role of the physiotherapist when goal setting with patients. The main impact of this article is that it supports a change in international and national physiotherapy policy and practice when goal setting with people with LTCs. Its economic benefit is that, by improving peoples' ability to self-regulate, it offers a more cost-effective approach to managing people with LTCs as it will reduce the demands on healthcare professionals and foster improvement in health outcomes.

3.2.3 Published article 3

Hartley, S. E. and Stockley, R. C. (2016) 'Collaborative goal setting with adults attending physiotherapy at a specialist neuromuscular centre: is it always appropriate? A cross-sectional survey.' *Physiotherapy*, 102(4) pp. 320-326.

Ethical approval: Manchester Metropolitan University, Department of Exercise and Sports Science academic Ethics Committee (IPS approval code 11.02.10(i)).

Link to publication - https://doi.org/10.1016/j.physio.2015.10.014

3.3 PUBLICATION 4

3.2.4 Background

The fourth article was conceived from an opportunity to undertake research at a social enterprise that offers a Wellbeing Service (WBS) for people with mental ill-health within social settings in the community. The WBS uses solution-focused interventions to foster self-advocacy so that individuals can learn to take responsibility for their own lives. Wellbeing Workers (WBWs) employ psychological therapies when needed and signpost to community groups and organisations that support people's HWB (Hartley, 2017). I knew that this research would not be relating specifically to physical health and not an area in which I had particular expertise. However, I recognised that the findings from this could build on my previous research. Particularly, it would help me to explore, further, self-management interventions, but from a mental health perspective rather than physical health. It would also enable me to gain more insight into mental ill-health and identify possible ways to collaborate with individuals to improve their psychological wellbeing. Therefore, it would support a more holistic approach to their management as explored in publication 1 and 2.

3.2.5 Research findings and impact

The findings highlighted the importance of partnership working with individuals to develop their innate capacity to manage their own condition. Helping people develop life skills so they have the confidence and capability to build positive social relationships and connect back into their community offered the opportunity

for further sources of support to help to self-manage. This study also supports the use of psychological therapies to foster mental wellbeing and endow individuals with the aptitude to make decisions about their own lives.

The importance of this study is that it reinforces the value of social enterprises in the health arena. It also offers, as a practical model, a social intervention for developing people's resourcefulness to become more independent and self-manage in the community. Such concepts could be transferred to the physical arena to support not only the HWB of people with LTCs but also enhance their ability to function socially and engage back into the community, hence fostering more inclusivity and social equity.

3.2.6 Published article 4

Hartley, S. E. (2017) 'Service users' perceptions of an outreach wellbeing service: A social enterprise for promoting mental health'. *Community Mental Health Journal*, 53(7) pp. 842-851.

Ethical approval: Manchester Metropolitan University Academic Ethics Committee (Faculty of Health, Psychology and Social Care) (Reference no 1228)

Link to publication - https://link.springer.com/article/10.1007%2Fs10597-016-0079-2

CRITICAL COMMENTARY OF PUBLICATIONS 3 AND 4

3.2.7 Introduction

Models of care that adopt asset-based approaches that support people to manage their own HWB have become increasingly popular by policymakers and commissioners of healthcare (Social Care Institute for Excellence (SCIE, 2017). Asset-based approaches build on the concept of salutogenesis, which is concerned with the promotion of positive HWB as opposed to cure or prevention (Antonovsky, 1996). The main emphasis is on what makes people healthy rather than illness and the deficits associated with this, with the focus being on a person's strengths rather than their problems (Whiting et al., 2012). Assets, which can be of individuals, groups and communities, are the capabilities, skills or resources that can be utilised to help people take more control of, or improve, their life situation (McNeish et al., 2016). As this includes the promotion of psychosocial, as well as physical health, it can, thus, provide a holistic and patient-centred approach to HWB (Rippon and Hopkins, 2015). With the aim of these approaches being to foster personal empowerment for HWB management by providing access to more health resources, it could potentially help to redress health inequalities and provide more cost-effective and sustainable care (Morgan and Ziglio, 2007).

3.2.8 Critical commentary

The WBS uses solution-focused interventions to facilitate self-management. They do this by following an asset-based approach in which individuals' own innate potentials are harnessed so that they can resolve their own problems (Hartley, 2017). The role of, in this case, the WBWs are to assist individuals to recognise

and build on their own resources so that they can manage their mental wellbeing and take control of their own lives (Hartley, 2017). Although the WBS primarily offers support for people with mental ill-health, it could provide a template that could be used to support the mental wellbeing of individuals, such as those at the NMC, who have physical LTCs. Using a solution-based approach, in this way, could assist individuals to cope better with their condition by helping them to move their attention away from what they cannot do, to what they can do (Roy et al., 2017). Therefore, placing focus on what can be controlled in their life rather than what cannot, could help to reduce anxiety about their condition and bring a renewed sense of hope for the future (Hartley, 2017; SCIE, 2017). The role of the health professional, therefore, is not "to do to", but to collaborate with individuals to support them to draw on their own resources and assist them to the point where they feel able to make their own decisions about their condition (Gripper and Murray, 2017). This could be particularly apt for people with LTCs as, through lived experience, they have the capacity to become their own experts and, therefore, make their own decisions about their HWB (Hartley et al., 2011). Developing a therapeutic relationship that is based on collaboration and a shared endeavour is therefore vital to its success (Hartley, 2017).

An example of how this could be put into practice can be taken from the Bridges Self-management Programme (SMP) that has been found to be a feasible addition to community rehabilitation for survivors of stroke (Jones et al., 2016). As a tailored SMP, it aims to support LTC self-management by cultivating patients' problem-solving skills and their ability to set personalised goals (Jones et al., 2017). Collaboration with shared decision-making between practitioners and patients is seen as key for developing opportunities to build patients' mastery

(ability) and self-efficacy (confidence) to be successful in these undertakings (Jones et al., 2016). In addition, as training for practitioners is a pre-requisite for utilising the Bridges SMP, and an individualised handbook for patients is employed as a resource to facilitate the collaborative process (Jones and Brimicombe, 2014), both practitioners' and patients' capacity for partnership working could be enhanced.

At the WBS, psychological therapies were often used as a tool to help people manage their mental health (Hartley, 2017). Certainly, the use of psychological therapies is becoming increasingly prominent in the physical arena to support people to develop the emotional capability to cope with their situation (McGrane et al., 2015). Using psychological therapies, in this way, could facilitate people with LTCs to develop their readiness to take responsibility for self-managing (Driver et al., 2017) and, hence, nurture a more collaborative partnership. Assisting individuals to develop strategies, such as goal setting (Hartley and Stockley, 2013) and problem-solving, can also help them to move forward in their lives by inspiring the confidence that they can shape their future in a positive way (Nielsen et al., 2013).

Fostering the independence of people with LTCs to manage their own HWB will lead to less dependency and, hence, demands on healthcare systems (Grady and Gough, 2014). Nevertheless, although living with a LTC is a unique and personal experience, it is not a journey that is taken in isolation but one that is shared with other people (Bennett et al., 2014). Asset-based interventions recognise the value of having these social connections with others, for it is through the development of these interconnected relationships that resources and emotional support can be mutually shared (Foot, 2012). This was reflected at

the WBS, where people were supported to develop their ability and self-confidence to cultivate relationships that are more positive. They were also directed to community groups and organisations, depending on personal predilections, that fostered hobbies and interests, employment or volunteering opportunities (Hartley, 2017). Assisting people with LTCs to access resources such as these could help to enhance their capacity to self-manage through the acquisition of skills and emotional support besides nurturing their participation back into the community (Best et al., 2014). It would seem, therefore, that facilitating people with LTCs from dependency to independency should only be a stepping-stone, with interdependency being the ultimate aim, as this could optimise their capacity to self-manage and live more fulfilling lives in the community (White et al., 2010). Developing the ability and the emotional capacity to cope with their situation were important considerations when setting goals at the NMC, though; this was to foster more independency for managing their condition (Hartley and Stockley, 2013). As individuals become more independent, personal goals that are focused towards life skills that nurture relationship development and socialisation into the community would, however, seem more pertinent as this will facilitate more interdependency (White et al., 2010).

Nevertheless, there are criticisms to asset-based approaches, not least that it is government rhetoric to reduce their costs and responsibility towards healthcare (MacLeod and Emejulu, 2014). Indeed, the approach in itself is not novel. Its concept has been promoted in the community development arena, particularly in the USA, since the early 1990s (Kretzmann and McKnight, 1993). Its increased popularity has come at a time where austerity in healthcare is prominent, and a cost-effective way to manage health is seen as essential (Stuckler et al., 2017).

Additionally, as more emphasis is being placed on self-management, it can potentially lead to greater health inequalities and further marginalisation from others if the required support to self-care is not provided to everyone that needs it (Friedli, 2013). Consideration also needs to be made to those people who do not have the capacity to become self-determining (van de Bovenkamp and Dwarswaard, 2017). Therefore, asset-based approaches alone will not support all aspects of care for everyone with LTCs; however, it could co-exist alongside needs based models to offer interventions that are more comprehensive for people with LTCs (Brooks and Kendall, 2013). Nevertheless, there are challenges to its implementation as it involves new ways of working with no standardised approach to follow. It could also initially be resource intensive, for there will be costs for training staff and supporting its implementation (Gripper and Murray, 2017). Therefore, continued government support would seem essential to ensure that it remains viable (Foot, 2012).

3.2.9 In summary

Assets based approaches can offer a holistic and patient-centred model of care that can help to optimise the capacity of people with LTCs to self-manage. Supporting individuals to look beyond their physical impairment, and focus towards a more hope-inspiring future, can help people with LTCs learn to live a more fulfilling life in their community in spite of their condition. Developing partnerships between formalised healthcare and social enterprises that have the potential to drive asset-based approaches in the community, could add to its success.

3.3 LESSONS LEARNT

The response rates for the questionnaires in publication 2 and 4 were notably different. At the NMC, it was 78% but only 29% at the WBS. However, there seems no definitive definition of what an acceptable response rate should be for questionnaires, with many different views as to what is most appropriate (Morton et al., 2012). Lower response rates have been linked to a reduction in statistical power and higher confidence intervals in statistical tests (Baruch and Holtom, 2008). However, some studies with low response rates, including as low as 20%, have been found to be more accurate than those with returns of up to 70% (Visser et al., 1996). Cook et al. (2000) claim that having a range of characteristics that are representative of the population is more important than a high response rate that does not achieve this. Although my response rate at the WBS was low, the participants had a range of characteristics, including different genders, age ranges, ethnic groups and employment status.

Nevertheless, I have learnt from undertaking these studies that, in addition to considering the best methodology to answer the research question, you also need to think about the client group as this may influence the ability to collect data. This is particularly the case with people who are hard to reach such as those with mental ill-health where response rates to questionnaires are often low (Sydor, 2013). This is reflected in the annual UK national community mental health survey that has achieved, at best, a 29% response rate (Care Quality Commission, 2016). People with mental ill-health may not have the motivation or the capacity to be research participants due to their psychological distress (PHE, 2017a). Additionally, people with mental health problems are more likely to have housing difficulties and financial problems and, because of this, move house

often, or are of no fixed abode (Bramley et al., 2015). This became apparent to me after I had posted out questionnaires and received mail back with “not at this address" written on. To enhance the response rate I had to include other methods and gain further ethical approval to permit this. Text messaging was found to be particularly productive for contacting clients at the WBS with a link to SurveyMonkey. However, I am also aware that not all clients may have smartphones to access the survey. Consideration of how participants gain the information and the issues that this may bring is, therefore, vital. Bonevski et al. (2014) highlight the need to use methods that are more diverse to access hard to reach groups. Therefore, incorporating a variety of methods that would be more appealing to people in different ways seems most pertinent, and will be considered in future research.

The inclusion of open-ended questions on the questionnaires was valuable as it did offer more insights. However, answering open questions is more time consuming and, therefore, may demotivate some people from taking part, particularly people who do not have much to say, or those who are illiterate (Egeland et al., 2017). Therefore, providing shorter surveys with closed questions only, or survey interviews, maybe a more successful option for some client groups such as those at the WBS.

Accessing and engaging people who may not be motivated to take part in research is always going to be problematic (Bonevski et al., 2014). Certainly, the lack of credible research can influence health outcomes for this group of people. What seems vital, though, is that a variety of methods is used to access the participants. A low response rate provides limitations as it lacks full representation of the population under study. Nevertheless, it is important that

those who have something to say be given a voice, and those who have chosen not to take part have at least been provided with the opportunity. As Sydor (2013) highlights, it is better to have limited data that is well analysed than no data at all.

3.4 CHAPTER SUMMARY

This chapter has been concerned with building personal assets to support an individual's ability to self-manage but also to facilitate their socialisation back into the community. However, this will only be successful if an environment is created within the community that fosters their participation, otherwise disparities and a lack of desire to engage with others may still prevail. The next chapter will, therefore, consider how community space can be shaped to enhance citizen participation.

4 ACTIVE AND HEALTHY AGEING

This chapter will present publication 5 to explore how older adults can be supported to age healthily through the promotion of their health and wellbeing (HWB).

4.1 INTRODUCTION

Endorsed by WHO, active and healthy ageing (AHA) initiatives attempt to address the challenges faced by an ageing population (WHO, 2002; WHO, 2015). Although there is no definitive definition of AHA (Bousquet et al., 2015), its ambition is to create environments and provide equal opportunities that foster personal empowerment and the social participation of older adults in society (WHO 2002: WHO 2015). In doing so, it acknowledges that older adults are assets with skills and attributes that can be optimised so that they can realise their potential and continue to contribute to their communities (Forster and Walker, 2013; Hornby-Turner et al., 2017). AHA's focus is towards the promotion of wellbeing (physical, mental, social, spiritual and cultural), thus offering a holistic approach to health (Forster and Walker, 2013; Bousquet et al., 2015). The aim is to support older adults to maintain their functional ability and live an independent, safe and what they perceive to be a good quality life that has meaning and worth (WHO, 2015; Beard et al., 2016). Evidence suggests that physical activity (PA) supports AHA as it promotes HWB, and the primary and secondary prevention of LTCs (WHO, 2002; Daskalopoulou et al., 2017), and enhances the quality of life of older adults (Killingback et al., 2017). However, as there is a general decline in PA levels as people age (Baert et al., 2011), the benefits of engaging in PA for older adults are not being fully realised.

4.2 PUBLICATION 5

4.2.1 Background

At the time of undertaking this research, community PA groups for older adults were becoming increasingly popular as they were seen as a cost-effective way to improve their PA levels (Frew et al., 2014). However, there were limited studies concerning long-term adherence to these groups. As it has been found that health benefits can only be gained from participation in PA on a continual basis (Sun et al., 2013), gaining more insights into older adults' adherence to PA groups would, therefore, seem key for optimising their HWB. Incorporating groups who are less likely to engage in community PA (Lim and Taylor, 2005; Hughes et al., 2011) would also help to foster the implementation of more inclusive strategies that inspire the engagement of diverse groups of older adults.

4.2.2 Research findings and impact

This publication promotes the physical and psychosocial benefits of attending PA groups for older adults. It also highlights the importance of the environment in promoting PA engagement. This includes providing accessible and adequate social space for PA to take place. However, it is the activities and the social interactions that take place within the groups that were found to be key to fostering long-term adherence. Additionally, promoting cross-cultural relationships and facilitating people to become empowered to shape their own environment was highlighted as being more advantageous in fostering the long-term adherence of groups that are more diverse.

The importance of this publication is that it promotes strategies that foster the HWB of older adults through health promotion, prevention and management that

can be adopted both internationally and nationally, hence helping to inform future health and ageing policies. Targeting minority groups and those that are less likely to attend PA groups endorse initiatives that support integration and diversity in the community (Greater Manchester Health and Social Care Partnership (GMHSCP), 2017). Therefore, as well as promoting HWB by facilitating health equity it can foster more community cohesion (Runnymede Trust, 2018). Additionally, as this research was undertaken in the Manchester region, the impact of this publication is particularly important locally to enhance service provision, as Manchester has one of the highest ill-health and premature death rates (Regan, 2016). It is also one of the most deprived areas in England (Department for communities and local government, 2015) and has a diverse minority ethnic population (GMHSCP, 2017).

4.2.3 Published article 5

Hartley, S. E. Yeowell, G. (2015) 'Older adults' perceptions of adherence to community physical activity groups'. *Ageing and Society*, 35(8) pp. 1635-1656.

Ethical approval: Manchester Metropolitan University Academic Ethics Committee (Faculty of Health, Psychology and Social Care) (reference no 1139, 2012)

Link to publication **-** **https://doi.org/10.1017/S0144686X14000464**

CRITICAL COMMENTARY OF PUBLICATION 5

4.2.4 Introduction

As evidence for the potential of social relations for improving overall health increases, there has been renewed interest in social networks (Tsai and Papachristos, 2015). Social networks are social structures in which individuals, groups or communities become interconnected through interaction and the development of personal relationships (Kenis and Oerlemans, 2009). Networks may include family, friends, work colleagues, or people who have similar interests, hobbies or beliefs (Li and Zhang, 2015; Windsor et al., 2016). The benefits of belonging to a network are opportunities to access resources such as social support or information and advice that can help shape health behaviour (Cornwell and Laumann, 2015; Growiec et al., 2018). This has been found to be influential in improving HWB (Cornwell and Waite, 2009; Moore et al., 2018) and reducing both the decline in cognition (Ellwardt et al., 2015) and mortality (Litwin and Shiovitz-Ezra, 2006). As they have the ability to improve health outcomes in the older population, harnessing the potential of social networks in this arena has become more relevant (Li and Zhang, 2015).

4.2.5 Critical commentary

In this publication, the ability to interact and build relationships with others was found to be key to fostering adherence to the PA groups (Hartley and Yeowell, 2015); hence the social networks that were developed and, specifically, the social environments that were created within the networks due to the interplay between the older adults and the activities that they undertook (Hartley and Yeowell, 2015). Therefore, it would seem that older adults' adherence to PA groups can be

cultivated if opportunities that facilitate the development of these “networks of interconnected relationships” are provided (Kenis and Oerlemans, 2009:290). This is because it would foster their ability to play a part in shaping their own environments within the PA groups to support their collective needs (Cattell et al., 2008).

As seen in this publication, the older adults had become more involved in the organisation and running of the PA groups including arranging guest speakers or being involved in decision making at the user group meetings (Hartley and Yeowell, 2015). Having more responsibility for the groups, in this way, offers the chance to develop these interrelationships, as tasks would need to be agreed upon and shared (Dominguez and Arford, 2010). However, it was also clear that disparities in characteristics between the subgroups had influenced their wish to connect with others in the group and, hence, adhere. More specifically, it was differences in cultures for those of BAME backgrounds, and dissimilar conversational interests for men in female-dominated groups (Hartley and Yeowell, 2015). This resonates with recent research that has identified the potential of cultural adaptations for improving PA adherence in minority groups who, like the population in this publication, are less likely to adhere to PA (Horne et al., 2018). Cultural adaptations are modifications to the group that include elements of that culture or characteristics such as, language, values and norms to enhance its effectiveness and desirability to undertake (Nierkens et al., 2013). Certainly, the older adults, by having more accountability for the groups, could now be instrumental in not only identifying the changes that need to be made to tailor to the group requirements but be more motivated to ensure the necessary modifications are made (Ormsby et al., 2010; Warburton et al., 2013).

Indeed, since this publication, the older adults have taken on more ownership of the PA groups and have been actively involved in the setting up of other groups and activities in one of the premises. As losing weight was identified as a particular motivation for them to adhere to the PA group (Hartley and Yeowell, 2015), healthy eating classes and Slimming World have been introduced to support this need. Having access to additional social networks offers the older adults more diverse resources, in this case, to support their HWB and, thus, their ability to age healthily (Vassilev et al., 2014). However, as highlighted in the publication, the older adults are only likely to engage with other groups if there is someone to whom they can already relate in that group (Hartley and Yeowell, 2015). Having already developed relationships with their peers, together they may be encouraged to not only access other groups but also provide each other with a source of support to inspire their continual attendance (Zhang et al., 2015). Nevertheless, although this offers the potential to link across subgroups of older people and, thus, enhance inclusivity, it may exclude other subgroups, hence leading to health inequities (Cornwell, 2011). For example, activities focused on losing weight may not appeal to some minority ethnic groups where women of a larger size can be more admired (Davidson et al., 2013; Horne et al., 2018). Additionally, some individuals or groups may have more sway on what takes place than others (Perkins et al., 2015). However, this could also provide opportunities, for example, championing those with more influence to promote positive health behaviours within the group (Perkins et al., 2015). In the case of this publication, it could be the older adults who are involved in decision-making at the user group meetings. Additionally, incorporating older adults into the PA

groups who are trained in cultural awareness could support a greater connection between more diverse groups (Dominguez and Arford, 2010).

The older adults also found that having access to health professionals who offered advice and education fostered their adherence, as it supported their self-management (Hartley and Yeowell, 2015). This is particularly encouraging, as it has been found that people whose HWB is deteriorating are more likely to disengage from social networks that could be beneficial to health due to the burden of their condition (Li and Zhang, 2015). Consequently, the benefit of continuing to participate in PA groups will be lost and may lead to further deterioration in health (Li and Zhang, 2015). This would include the physical benefits that were identified by the older adults that were attending the cardiac rehabilitation class (Hartley and Yeowell, 2015). Although there were PA groups to support people with cardiac and respiratory conditions, there was a lack of tailored groups for older adults with other morbidities (Hartley and Yeowell, 2015). Therefore, an opportunity exists to set up PA groups for more diverse ranges of health conditions, which could also facilitate their engagement in the community (Milner and Kelly, 2009). Having more involvement by healthcare professionals would also provide older adults with access to more resources that can promote their HWB. Reciprocally, healthcare systems could benefit from these partnerships as, potentially, they offer a more cost-effective way to support the self-management of people with LTCs in the community by offering efficient use of limited healthcare resources and promoting more equity in healthcare (Blickem et al., 2013).

Of note, measurements for adherence were not used in this publication, which may be deemed a limitation. Nevertheless, their inclusion in other research has

been inconsistent as there is no optimal approach identified (Farrance et al., 2016; Hawley-Hague et al., 2016; Killingback et al., 2017). It could also be claimed that, by only considering people who have adhered to PA groups, the voices of those who have not will be missing. Therefore, future research needs to incorporate older adults who have not adhered as this may provide additional insights into the long-term adoption of PA groups.

4.2.6 In summary

Social networks could provide a valuable tool for fostering the adherence of diverse groups of older adults to PA. Having access to more varied, health-focused networks provide opportunities to obtain additional resources that support healthy ageing. However, to harness these benefits, the ability to nurture the environment to support the collective needs of older adults is key.

4.2.7 LESSONS LEARNT

To help me identify and access the most appropriate groups that would support my undertaking of this research, I knew I needed to find a gatekeeper. Finding details from the local government website, I made contact with a Community Officer for older people who invited me to a PA user group meeting that provided me with initial access to relevant groups. As the groups were in different areas, I also wanted to engage the leaders of each individual group. Two of these gatekeepers were very helpful and set up meetings with their groups, so that I could discuss with them details of the research including what it would entail. However, one of the gatekeepers who ran one of the PA groups seemed particularly reticent of me having access to her group for my research when I first contacted her by telephone. I, therefore, asked her if I could meet up with her to

explain in more detail about the research. On my second meeting, during a discussion, it became apparent that another individual had undertaken research previously with this group and they had subsequently placed a video of the group conducting their PA class on YouTube without gaining permission for this. When I explained exactly what I intended to do and assured her that I was not taking any videos of the PA, she was much more amenable. I also made clear that I would keep in contact and report the findings of the research back to the group. Following this, she was happy to provide access to this group.

This identified to me the significance of the relationship that is developed with the gatekeepers when carrying out the research as they can influence the ability to undertake the research and the research process (McFadyen and Rankin, 2016). I, therefore, realised that prior to any future research I needed to consider contingency plans for if access is denied (Singh and Wassenaar, 2016). I will also know in future that if the gatekeeper seems reluctant to allow access then they may have genuine reasons for this and, consequently, it is important to understand their situation and their views and beliefs about the research. In this case, it was because of a previous negative experience and not having a clear understanding of the intentions of the researcher. As the gatekeeper was involved in leading the PA group, she may also have been worried that she was being evaluated and that the findings may misrepresent her and put her in a negative light (Gray, 2013). It may also be that the gatekeeper feels responsible for the welfare of the potential participants and, consequently, will want to ensure that they are going to be treated fairly (McFadyen and Rankin, 2016). As a researcher, I have therefore learnt that all potential concerns, such as these, need to be considered and addressed if highlighted as an issue by the

gatekeeper. In the future, I would always ensure that I communicate all aspects of the research to the gatekeeper including the purpose, what it entails and what the data will be used for and how they will be kept up-to-date with the findings (Singh and Wassenaar, 2016). In the case of this research, I re-attended the user group meeting where I presented back the results to the older adults and a representative from the local government who was present.

4.3 CHAPTER SUMMARY

This chapter has considered ways that environments can be shaped to foster community participation and the self-management of HWB. The next chapter will explore how a healthcare workforce can be developed to drive transformation in practice to support the optimisation of HWB in the community.

5 HEALTHCARE WORKFORCE

This chapter will present publication 6 and will explore how healthcare workforces can develop new ways of working that support more sustainable means to promote the HWB of older adults and people with LTCs.

5.1 INTRODUCTION

The NHS is trying to reinvent itself as, in its present form, it is unsustainable (NHSE, 2014; NHSE, 2017). However, as this transition takes place there is increasing pressure on health professionals to not only modernise themselves but also be able to continue to evolve to support the future needs of society (NHSE, 2017). This is coming at a time where staff recruitment and retention levels are low, leading to shortages in the NHS workforce (NHS Providers, 2017). This places demands on the workforce that can have a detrimental effect on patient outcomes (Majeed et al., 2018). Therefore, to continue to provide quality care and better health outcomes, health professions will have to rise to the challenges faced by finding new ways of working that are more cost-effective and sustainable (Eckert et al., 2014).

5.2 PUBLICATION 6

5.2.1 Background

The impetus for publication 6 grew as I started to develop my own research in the LTCs and older adults' arena, and became more engaged with the current literature in this area. I was aware of the challenges faced by health professionals as the healthcare environment was rapidly changing. However, the findings from my research illuminated the opportunities that were available to both optimise

care for people with LTCs and the contemporariness of health professionals in this dynamic healthcare climate. I was specifically concerned about the physiotherapy profession as my background is in physiotherapy but also because they have a key role in the management of people with LTC (WCPT, 2017). I thought the insights that I had gained from my research could be valuable and empowering to physiotherapists and encourage them to take responsibility for change (Hussain et al., 2018). Having a good understanding of the need for transformation could also enhance their readiness to take action (Ming-Chu and Meng-Hsiu, 2015). My sixth publication is, therefore, an amalgamation of all my research findings that are discussed within the context of a critical review of the literature. The intention of this publication is to open up a discussion amongst the physiotherapy profession of the role of the physiotherapist when managing people with LTCs in order to inform future practice and build momentum towards taking action.

5.2.2 Research findings and impact

The findings of this publication propose that physiotherapists need to be more attuned to their patients' biopsychosocial requirements so that patient-centred holistic care can be optimised. It also advocates the need to cultivate multi-sectoral partnerships where resources and expertise can be shared as this provides the potential to become more cost-effective and sustainable. Additionally, it contends that by integrating health promotion and behavioural change strategies into their practice, physiotherapists can mitigate the occurrence of LTCs and hence help to change the future healthcare landscape.

The importance of this publication both internationally and nationally is to inform physiotherapy policy and inspire change in the physiotherapy profession in both practice and undergraduate education. This is particularly topical with the recent release of the Chartered Society of Physiotherapy (CSP) information paper on the future shape of the physiotherapy workforce, which includes concepts discussed in this publication (CSP, 2018). This publication also promotes the advancement of the profession by advocating ways for physiotherapists to be more at the forefront of care. This is significant because capturing the attention of commissioners and decision-makers who are responsible for procuring physiotherapy services is essential at a time of financial constraint (Naylor et al., 2015). Additionally, this publication promotes health practices that could potentially be more cost-effective and sustainable, aspects of which can be transferable to other health professionals. The impact on society is that it fosters the HWB of the whole population as it champions both health promotion and prevention initiatives as well as management of conditions. It also advocates strategies to enhance the quality of life of people with LTCs as well as reduce health disparities.

5.2.3 Published article 6

Hartley, S. E. (2018) 'Re-imagining the role of the physiotherapist when managing people with long-term conditions'. *Physiotherapy Theory and Practice*. [Online] 'First online' published 3rd May 2018. [Accessed on 6th December 2018] DOI: 10.1080/09593985.2018.1467989.

Link to publication - **https://doi.org/10.1080/09593985.2018.1467989**

CRITICAL COMMENTARY OF PUBLICATION 6

5.2.4 Introduction

The social or wider determinants of health (SDH) are increasingly seen as the most significant factor for influencing the health of the population and the leading cause of health inequalities (Marmot, 2010). The SDH are the circumstances that people are born into, grow, live, work and age (WHO, 2010). These include the social, economic, physical and political environments and personal behaviour (Lovell and Bibby, 2018) (See Figure 5.1). Social determinants are interlinked and throughout a person's life have a cumulative effect on their health (Kindig and Stoddart, 2003).

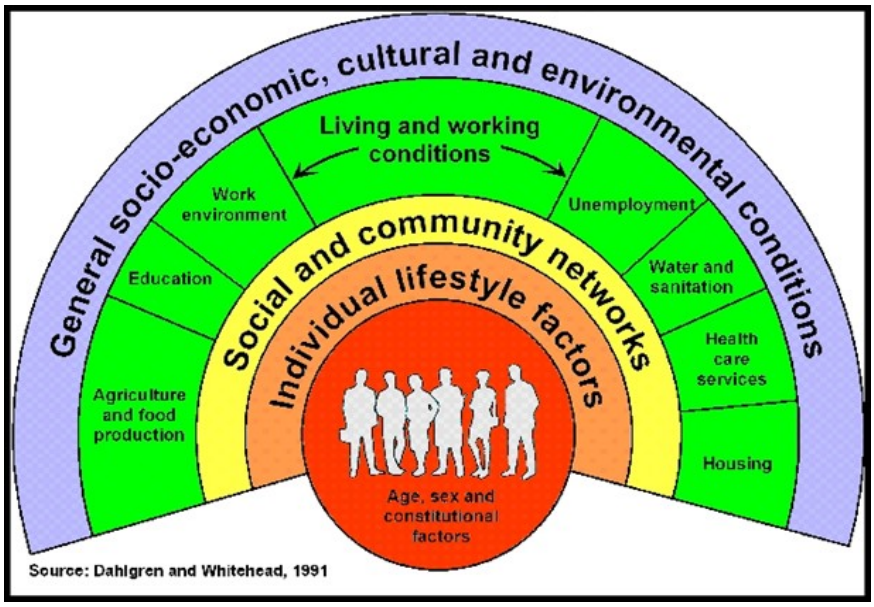

Figure 5.1: Determinants of health

To help to address the impact that SDH have throughout people's life course, there has been a shift in focus towards the promotion of interventions that influence population health, rather than health at the individual level (Alderwick et al., 2015). Population health, though, is difficult to define, as there is no

consensus as to what it is (Buck et al., 2018) and, at times, it has been used synonymously with public health (WHO, 2018b). However, population health can be said to be more encapsulating than public health as it is concerned with improving both health and wellbeing outcomes of the whole of that population, whether that be the nation or the local community (The King's Fund (TKF), 2019). In addition, by considering the distribution of those outcomes within different groups in that population, such as those with LTCs or people with specific age groups, it can help to improve health equity by targeting interventions to those of most need (Kindig and Stoddart, 2003; TKF, 2017). Population health aims to do this by addressing all the determinants of health such as the broader influences, for example, housing and the physical environment (Siegel et al., 2016; TKF, 2019). It, therefore, fosters collective commitment from across all areas of society, not just the public health workforce, for promoting health and preventing ill-health (Buck et al., 2018; Masic, 2018). This includes sectors like urban planners and housing associations (TKF, 2019). Thus, population health, being seen as an evolving public health care system, facilitates new approaches that support the optimisation of HWB across the whole population (PHE, 2016; Siegel et al., 2016).

5.2.5 Critical commentary

Publication 6 espoused the need for physiotherapists to become more involved in public health promotion and prevention (Hartley, 2018). Public health promotion and prevention programmes support population health as they aim to keep people healthy by enhancing their ability to take control of their own HWB (Richmond Group, 2014). They are also more focused on mitigating SDH by

improving people's awareness of modifiable risk factors for health and helping them to make healthier lifestyle choices (Newton et al., 2015). As highlighted in this publication, physiotherapists could assist in preventing the occurrence of many LTCs by including behavioural change interventions that promote PA, smoking cessation, lower levels of alcohol consumption and eating more healthily (Hartley, 2018). Thus, health promotion and prevention programmes are potentially cost-effective as they can reduce the future burden of LTCs on individuals, healthcare professionals, health systems and society (Newton et al., 2015). However, incorporating a population health approach that takes into consideration other determinants that may be affecting a person's health such as, poor housing conditions, unemployment and social isolation, could offer physiotherapists further opportunities to improve health outcomes as well as reduce health disparities amongst the population (Donkin et al., 2018). Nevertheless, as identified in this publication, to enhance physiotherapists' capacity to undertake these initiatives realistically, multi-sectoral partnerships would need to be developed (Hartley, 2018). Certainly, there are resources and expertise within the community that can support physiotherapists in this endeavour and making the best use of these assets will help to enhance the sustainability of these interventions in the future (Foot, 2012; Hartley, 2018). For example, physiotherapists may signpost to Shelter or Citizen's Advice for housing difficulties, job clubs to enhance people's ability to gain and undertake work or PA groups to improve social contact with others. Indeed, working towards population health in this way could help to facilitate more multi-sectoral collaborations and more collective responsibility for health within the community (Corbett-Nolan et al., 2018).

Sharing responsibility for population health across sectors can also offer a more sustainable way to support people with LTCs to self-manage and optimise their own care in the community (Siegel et al., 2016). By fostering self-empowerment for managing their own condition and offering access to more resources, both health equity and outcomes within this population group can be improved (Taylor et al., 2014). However, to enhance patient-centred care and optimise self-management support, this publication identified the need to tap into the biopsychosocial requirements of their patients (Hartley, 2018). Incorporating the wider determinants, such as the person's social and cultural circumstances, would enhance the physiotherapist's ability to provide more holistic care to support these biopsychosocial needs (Andermann, 2016). For example, in Manchester, a collaboration between the local government, the NHS, and voluntary organisations has led to the establishment of self-care groups in an area that is socially deprived. Community organisations and trained volunteers, as well as access to social networks, have provided peer support and education for people who are isolated and live in poor social situations. For instance, people out of work and minority ethnic groups are assisted to manage their own social circumstances and become more engaged within their community (Regan, 2016). Being involved in partnerships that help to reduce social disparities in this way can enhance opportunities for physiotherapists to help to improve both health outcomes and equity within the community (PHE, 2017b). The physiotherapists' role, in this case, could be to educate volunteers to provide appropriate support to help people with LTCs and their carers to manage their condition so that they can remain in the community.

However, a threat to such transformations of practice for physiotherapists is the inability or unwillingness of the workforce to make the necessary transitions and, hence, they could become left behind (CSP, 2013). Providing opportunities for staff to be involved in creating a shared vision for the future profession could give them something to work towards and motivate them to achieve it (Martin et al., 2014). The workforce consultation by Health Education England (HEE) has gone some way towards this by providing the opportunity for healthcare employees to inform policy about the future NHS workforce (HEE, 2017). However, more needs to be done at the professional level where physiotherapists can become more empowered to seek their own destiny.

To support population health, physiotherapists will need to be aware of both the demographics of their community and resources that exist to direct people to (Meek et al., 2018). With the advancement of big data, more information is becoming available about the community's population and its health (Corbett-Nolan et al., 2018). Therefore, it is essential that physiotherapists know where to tap into this data and the best ways to use it. Lack of financial support for undertaking health promotion and prevention programmes could also hinder the benefits gained from these approaches. The overall healthcare expenditure towards ill-health prevention was 5.2% of the total healthcare budget in the UK in 2015 (British Medical Association (BMA), 2017), thus suggesting that the majority of funding is still being spent on treatment and plugging gaps in budgets (BMA, 2017). This, therefore, diminishes the incentive to engage fully in these programmes. This may be augmented as health outcomes, as a consequence of promotion and prevention initiatives, may take longer to materialise; therefore, they may not be given the priority as their success cannot

be easily demonstrated (Masters et al., 2017). Consequently, both institutional support to undertake these changes and more government spending is required to foster the success of transformation towards population health management.

5.2.6 In summary

Physiotherapists, by adopting approaches that promote population health, could enhance their public health role by developing new initiatives that support improvements in both outcomes and equity in health amongst the whole of their community, thus helping to reduce future cases of LTCs. Working as part of a healthcare system to address the SDH could enhance their ability to provide cost-effective and sustainable healthcare that promotes the HWB of both people with LTCs and older adults by supporting their biopsychosocial needs.
However, to foster transformation, a shared vision of the future of physiotherapy practice needs to be envisaged by the profession.

5.3 LESSONS LEARNT

As this publication was written based on my previous findings and critical reflections, it is important to explore my own philosophical assumptions and the experiences that I have had, as my own beliefs will shape my research in some way. With my research, I was attempting to comprehend the world of others so that I could tell their story. However, to make sense of participant's stories, I was mindful that, subconsciously, I would make connections with what I already knew or had experienced (Sousa, 1998). Therefore, I needed to ensure that I was not just representing my own preconceived views of another's reality.

In my research, I was motivated by a desire to give a voice to people who have not had the chance to be heard, but trying to do this by being authentic to them.

I am mindful that I am an outsider in this research in the sense that I was not part of the social enterprises or the PA groups where my research took place or the population groups that I have studied. Therefore, I may not be able to fully understand and, thus, represent all the nuances that may be particular to that group or, certainly, what they are truly experiencing as a group (Berger, 2015). Nevertheless, even within a collective, experiences are unique to each individual and, therefore, each will have their own personal stories to tell that, together, will become their shared repertoire (Bridges, 2001), the tapestry of which I am building through my own lens. This is the lens of what once was a clinical physiotherapist who, for 12 years, was mainly concerned with the physical management of patients. Some of these patients had LTCs and some were older adults, but many were young with short-term injuries that would get better. For the past 20 years, as a lecturer, my knowledge in the LTCs and older adults' arena has been developed through reading books and journals and interacting with my students and, more recently, my own research. Although I have an interest in psychology and the mind, body, connection on health, I had little experience in the mental health arena or knowledge about social enterprises. Therefore, as initially the research was relatively novel to me, it may be that I had less pre-supposition of what should be. If this is the case, looking through fresh eyes may offer the opportunity to provide new insights to this area that may otherwise have not been illuminated (Berger, 2015). To comprehend this more fully I have remained reflexive throughout by writing in my analytical diary to try to understand my thoughts and assumptions (Probst, 2015). I have also had regular peer review meetings with research colleagues and latterly my supervisor where, through critical discussions, I have been able

to scrutinise my own perceptions further. However, I am mindful that my interaction with the reviewers and the questions they asked could have influenced my understanding of the phenomenon under investigation (Walshaw, 2008).

My worldview on reality is that it is not out there just waiting to be found but is created by the people who take part within it. However, each will have their own unique representation of what is occurring (Bridges, 2001). I have also become an accomplice in this unfolding reality purely by my presence at the scene (Berger, 2015). I first became aware of the mutability of reality when I undertook my Master's Degree and was introduced to constructivism and the interpretative paradigm, which already resonated with me. For many years prior to that, I had read books on personal development. These taught me that by changing my thoughts I could change my perceptions of the world in which I was living. Unknown to me at the time, this would have been shaping my philosophy of life and future beliefs. My endeavour with my research has been to present the views and experiences of others and, by being reflexive, I have attempted to reduce my own influences on this. However, as it is my interpretation there will be a part of me within it. As a reader of my research, you also have become involved in the final narrative as you formulate your own meaning to it based on your own understanding and worldview (Pitard, 2017).

5.4 CHAPTER SUMMARY

This chapter has identified the potential of the healthcare workforce, specifically physiotherapists, to develop more innovative ways of working that support a healthcare system of the future for promoting the HWB of older adults and people with LTCs. The next chapter will provide a final discussion, drawing from the accumulation of this body of work, of how the HWB of older adults and people with LTCs can be optimised.

6 DISCUSSION

This chapter will critically discuss the significance of the body of work that I have presented in the light of current evidence. Although I have been more specific to physiotherapists, aspects of this could also be translated to other health professionals who work with older adults and people with LTCs.

6.1 INTRODUCTION

The purpose of this thesis has been to present the key findings from my publications and demonstrate how this body of work has evolved to advance understanding in the HWB arena in relation to older adults and people with LTCs. This is situated within the context of a transitioning healthcare system that is faced with the challenge of efficiency savings whilst improving the quality of care (DH, 2014). The focus of this work has therefore been towards community initiatives and innovative practice that could offer more cost-effective and sustainable ways to promote HWB.

6.2 CRITICAL DISCUSSION

WHO defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1946:1), thus implying that good health is a mode of being, a destination to reach (Smith, 2008). Certainly, this body of work highlights the biopsychosocial influences on the health of people with LTCs and older adults, therefore concluding that holistic approaches that consider these diverse perspectives and how they inter-relate together are essential for enhancing patient care (Hartley et al., 2011; Hartley and Stockley, 2013; Hartley et al., 2017). However, what these

publications have also identified is that HWB both for people with LTCs and older adults transcends the limits of physical, mental and social health alone. HWB for these people is not just about the ability to be physically or psychosocially independent but also about having hope for the future (Hartley et al., 2011; Hartley, 2017): being able to live a life that has meaning and purpose (Hartley et. al., 2011), an existence where they feel accepted, valued, and a sense of belonging to a place and people (Hartley and Stockley, 2013; Hartley and Yeowell, 2015). HWB is therefore about life itself, the daily experiences and all that these experiences have to offer. People with LTCs are never going to be cured and older adults as they age will start to deteriorate functionally (Beard et al., 2016). Hence, reaching for the “complete state of health” becomes unobtainable. Consequently, HWB for people with LTCs and older adults needs to be viewed not as an endpoint to attain but a unique life journey (Levin and Browner, 2005). A journey in which, in spite of their condition, people can be supported to live what they deem to be a healthy quality of life that has worth and value (Steptoe et al., 2015; Hartley, 2018).

Therefore, knowing what makes people healthy and shifting focus away from illness and what people cannot do, to wellness and what people can do, would seem to be more relevant when promoting HWB for people with LTCs and older adults (Lovell and Bibby, 2018). Incorporating asset-based models that draw on the strengths of individuals, as well as develop their resourcefulness, could, therefore, help to optimise their HWB (Gripper and Murray, 2017). As they aim to facilitate personal empowerment, they will also offer a more holistic patient-centred approach to care where people can be supported to live the fulfilling life that they aspire to (Rippon and Hopkins, 2015). Consequently, what is

important is not the doing to but the working with individuals in order to develop an insight into their world including their personal needs and their innate abilities (Gripper and Murray, 2017). Only by sharing their journey in this way can support be adapted to nurture their emotional resilience and foster their readiness to self-regulate (Hartley and Stockley, 2016; Hartley, 2017).

Although self-responsibility is important for supporting HWB, there are also other wider determinants of health that can influence people's HWB and their ability to self-manage (WHO, 2010). Certainly, the impact of the physical, psychosocial and cultural environment on the HWB for older adults and people with LTCs has been illustrated in this work. For example, offering PA groups in the community were found to enhance their HWB (Hartley and Yeowell, 2015). However, it was only by providing access to appropriate physical space and inexpensive classes that enabled these PA groups to take place and for the older adults to afford to attend (Hartley and Yeowell, 2015). Cost of attending was a particular concern for adults from the lower socio-economic groups and cultural adaptations was important for people from BAME backgrounds (Hartley and Yeowell, 2015). Therefore, unless environments are created that nurture the adherence of groups, such as these, who are already less likely to engage in these physical activities, greater disparities in health and outcomes will continue to occur (Healey et al., 2017). Exploiting the power of social networks for promoting HWB by facilitating the embeddedness of individuals from these diverse groups into them, can enhance the ability of older adults to shape their own environments to what they desire, thus fostering adherence. However, to achieve this undertaking, there needs to be mentoring that builds the capacity of the older adults to take ownership for the running of these groups (Foot, 2012).

Developing multi-sectoral partnerships can help to address these needs. For example, healthcare academics, educators and students could collaborate to design ways to work with groups such as these to support their requirements whilst also co-creating more novel community placements (O'Meara and Jaeger, 2006). Instigating students participation in this way can also facilitate creativity in the next generation of healthcare professionals in which the ability to drive innovative practice would seem essential (Scrutton et al., 2015).

It is of note that many of the older adults in this research were retired or widowed (Hartley and Yeowell, 2015). Life transitions such as these often lead to a loss in social relationships and, hence, a reduction in the social networks to which people have access (Cornwell and Laumann, 2015). These events, therefore, provide ideal opportunities to cultivate an interest in PA groups by tapping into the social needs of older adults (Cornwell et al., 2014). Championing PA initiatives and signposting by healthcare professionals to PA groups in the community, particularly at these life stages, would enhance their HWB promotion. Although not everyone with LTCs will have the physical capacity to engage in PA groups, the potential of social networks to promote HWB can be leveraged online (Arguel et al., 2018). For example, an online social network for people with NMD has been found to not only provide peer support and knowledge exchange opportunities to help with self-management, but also members inspired each other to maintain a positive outlook on life (Meade et al., 2018). Therefore, when promoting HWB, healthcare professionals need to keep abreast of such evidence-based resources so that they can direct people towards them when needed.

Social enterprises, in particular, whose social missions aim to reduce social injustices within their communities, also possess the capacity to address the wider determinants of health (Roy, 2017). This is reflected in this body of work that has demonstrated the ability of two social enterprises, for improving the HWB of people with LTCs by offering patient-centred holistic care (Hartley et al., 2011; Hartley and Stockley, 2013; Hartley, 2017). By influencing the SDH, they also helped to augment the life chances of service users. Providing access to healthcare to those who otherwise would not have had access to such services demonstrates this as it enhances health equity for these LTCs (WHO, 2010). Both enterprises also endeavoured to improve their clients' prospects for work. The WBS directed people with mental ill-health to job clubs in its community (Hartley, 2017). The NMC offered employment to people with NMD at the NMC as well as access to training courses to improve their employability (Hartley et al., 2011). Supporting people back to work is particularly significant for individuals with LTCs as they are less likely to be in employment (Bajorek et al., 2016). They are also more likely to be in the lower socioeconomic group (DH, 2012). Enhancing the employability of people with LTCs would help to improve their opportunity for wealth and, thus, potentially their social standing (Jackson, 2011). It can also boost community revenue by increasing productivity (Jackson, 2011).

Further lessons can be learnt from social enterprises for supporting peoples' SDH from an additional article that I have written from data that I collected at the WBS, and is under review for publication (Hartley et al., 2018). This research demonstrates how, by cultivating partnerships with other community organisations such as housing associations, recreational activities and faith

groups, wellbeing workers were able to direct people to appropriate resources that helped to enhance their HWB (Hartley et al., 2018). In the same way, if healthcare professionals become more aware of these resources and develop more collaborations in the community, they could link people to these assets depending on their HWB needs. Thus, offering more holistic and sustainable care could, potentially, be more cost-effective as resources can be shared (Naylor et al., 2017). However, they also need to ensure individuals have the life skills including the ability to cultivate relationships; otherwise, they will not have the capacity to connect back into the community and, hence, may continue to feel excluded (Hartley, 2018).

Embracing new models of care that incorporate approaches such as these could, thus, support the optimisation of people's HWB. It could also provide opportunities for physiotherapists, in particular, to transform their practice and continue to provide a contemporary service (Hartley, 2018). As this work has advocated, population health initiatives that support HWB promotion and prevention throughout a person's life course could also help to enhance the public health role (Hartley, 2018). Promoting population health throughout a person's life could assist in alleviating LTCs but also lead to healthy older people who can live more fulfilling lives (Tkatch et al., 2016). By incorporating approaches that aim to address the SDH, physiotherapists can help to improve both health equity and outcomes. Certainly, public health promotion and prevention approaches have been found to be a cost-effective way (Panagioti et al., 2014b) of improving health outcomes (Masters, 2017). For example, falls prevention was found to offer the fastest return on the expenditure of all public health interventions (Masters, 2017). However, physiotherapists' lack of both

confidence and perceived ability to undertake this needs to be tackled (O'Donoghue et al., 2014). Certainly, websites, handbooks and programmes to help with the upskilling of staff are easily available. For example, the Make Every Contact Count initiative (HEE, no date-a) and the Population Health and Prevention Network (HEE, no date-b) both include valuable resources to support health professionals in this undertaking. Love activity, hate exercise? is a new campaign by the CSP to enhance the skills and confidence of physiotherapists in educating their patients on PA and its HWB benefits (Hazzard, 2018). This campaign has been co-designed by physiotherapists and people with LTCs. Hence, it should be more effective in fostering the PA participation of people with LTCs as their needs and preferences would have informed decision making for its implementation (Hazzard, 2018). Additionally, being aware and getting involved in policy initiatives both at national and local level (WHO, 2013a) can help to shape the environment to support the promotion of HWB. For example, Salford physiotherapists incorporated PHE's health screening programme into their physiotherapy assessments (PHE, 2018). Not only did this foster population HWB but they also gained additional revenue from the government for its implementation (Rawlinson, 2016). Promoting and being involved in public health campaigns such as these can also put physiotherapists more into the forefront and, if successful, attract commissioners funding (Naylor et al., 2015).

Technology is advancing exponentially and physiotherapists can leverage its use to offer a more innovative approach for providing tailored support for HWB promotion of people with LTCs and older adults. For example, smartwatches and smartphone apps have been found to support both mental health and

physical fitness (Harwich and Laycock, 2018), self-management of people with LTCs (Dicianno et al., 2015) and the HWB of older adults (Mason, 2016). Making use of big data including feedback from smartphones and activity trackers can help to provide more tailored interventions in real time. Nevertheless, many apps have become ubiquitous and many are unregulated and not evidence-based (Kelli et al., 2017). Accessing NHS England's apps library, where programmes are available that are deemed credible for use to support HWB, could, though, help to counteract this (NHSE, no date). However, it would seem that further regulation and more research on their effectiveness needs to be undertaken.

There is also potential with virtual reality such as avatars, robotics or intelligent virtual agents and voice assistants, to revolutionise the future landscape. Systems like Alexa can be used at home to support the HWB of older adults and people with LTCs by providing health advice around the clock when needed. This could also include exercise prescription with regular reminders to undertake them to foster adherence (Siwicki, 2018). Presently, under trial is an electronic walking frame that works as a virtual physiotherapist for older adults. Through voice commands, it encourages people to engage in exercise and monitors their progress through feedback to their health professional (Hitchcock, 2018). This includes their gait pattern and daily activity so that the likelihood of falls can be identified and managed and their exercise prescription can be adapted as necessary (Hitchcock, 2018). Engaging in technology in this way can, therefore, provide opportunities for physiotherapists to support people in their community remotely, freeing up more time to spend with those of more need and for extending their roles in other areas such as further community

initiatives. However, for it to be optimised in this way it needs to be personalised to the ability of the individual and easy for them to use, particularly older adults who may not have the same technical ability (Mort et al., 2013; Mason, 2016). Otherwise, it could lead to disparity in provision and therefore greater health inequalities (Damant and Knapp, 2015).

In contrast to technology, physiotherapists can provide the human factor and, therefore, characteristics such as kindness, compassion, interpersonal skills and the ability to connect with others will become increasingly important (Friedman, 2016). In a dynamically shifting healthcare system, physiotherapists will also need to be innovative and flexible in approach with the ability to remodel themselves with the ever-changing nature of society and their requirements. Thus, the need to be resilient to change and uncertainty will be key. They will also need to be able to co-operate with and have value for people across different settings and levels of professionalism so that partnerships within the community can be developed (Imison et al., 2016). To rise to this challenge, a cultural change needs to take place within the profession particularly within pre-registration education, as these will be the future generation of physiotherapists (Dean and Duncan, 2016). With this in mind, I have undertaken further research that aimed to develop more insights into the future scope of the physiotherapy profession. Two focus groups, one with physiotherapy academic staff and one with undergraduate physiotherapy students were carried out to explore their perceptions of the role of the physiotherapist. The findings that were presented at the WCPT Congress highlighted, amongst both groups, an awareness of the changing role of the physiotherapist including more emphasis towards HWB promotion. However,

there was also the view that there was an incongruity between the University, physiotherapy practice and the external demands influencing the healthcare environment (Hartley and Yeowell, 2017) (see appendix 8.3.1). This supports the need for an open discussion across the physiotherapy profession to re-align these differences. Indeed, the CSP has acknowledged the necessity for transformation by publishing its own future vision of the physiotherapy workforce (CSP, 2018). This does provide a starting point. However, as it is having ownership in the process that has been found to inspire people to make the necessary changes (Martin et al., 2014), a consultation across all parties concerned would seem essential. Driving this forward at both national and international level could offer the critical mass needed to provide the tipping point for change to occur and adoption to be accelerated (Centola et al., 2018). Additionally, for innovation in practice to take place, an environment needs to be created that supports staff to undertake this including appropriate funding and time (Young, 2017). This could be problematic due to the changing global landscape that will shape governments' decisions and priorities. For example, in the UK, Brexit could lead to a reduction in financial outlay in healthcare until the economic future becomes more certain (McKenna, 2017). Furthermore, there will be a loss of European staff upon whom the NHS has increasingly become dependent (Fahy et al., 2017). This could, therefore, jeopardise the workforce strategy developed by Health Education England to improve recruitment and retention figures, thus leading to more demands on staff and less time for making the required changes (HEE, 2017).

6.3 IMPLICATIONS FOR PRACTICE

Globally, there is increasing interest in healthcare hubs that co-ordinate integrated care across multi-sectoral partners as they are seen as a way to provide more cost-effective and sustainable care (Govindarajan and Ramamurti, 2013; Bhatti et al., 2017). Incorporating the NMC and the WBS models into a hub and spoke design could offer a potential service for the future for supporting both people with LTCs and older adults (Elrod and Fortenberry, 2017). For example, the hub would be the regional healthcare centre that provides acute diagnostic and clinical management services, with the spoke being an integrated service in the community, providing specialist holistic care similar to the NMC. Resources can then be shared across these organisations, thus offering a more cost-effective approach and helping to reduce the pressures on healthcare budgets (Govindarajan and Ramamurti, 2013; Bhatti et al., 2017). Integrated holistic care, tailored to the local needs of older adults and people with LTCs, can then be provided within the community (Corrigan and Parish, 2014). Health professions such as physiotherapists can work with trained non-professionals, such as wellbeing workers who can provide psychological therapies when needed to optimise holistic care and promote HWB. The use of technology can provide further opportunities to enhance care in the community, particularly telehealth and telemedicine. Specialists at the hub can gain access to patients and their information at the spoke electronically, and provide follow up consultations and advice to patients through video or audio link (Govindarajan and Ramamurti, 2013). For example, respiratory function tests, blood pressure and other vital signs could be carried out by health professionals, or trained health workers at the spoke and relayed

to the hub. A more personalised service can then be provided, with only the complex, more acute cases being referred back to the hub. Developing further partnerships with organisations and groups in the community similar to the WBS that individuals could be directed to could further assist in promoting their HWB. This could include leisure activities and faith groups besides other social services, for example, housing associations and job clubs, thus helping to address SDH and support the engagement of older adults and people with LTCs back into the community.

6.4 IMPLICATIONS FOR POLICY

A threat to developing the integrated models of care is the lack of infrastructure that supports safe and efficient data collection and sharing within and across multi-sectoral organisations (Butler et al., 2015). Global policy initiatives are therefore needed to foster the optimisation of health information technology (Butler et al., 2015). Nationally, this will include centralised standardised platforms so that transferability of data across different systems is ensured but with the means to tailor to local requirements that support population health (Sheikh, et al., 2015: Wachter, 2016). Additionally, policies need to support and provide enticements for collaborations between multi-sectoral organisations and groups (WHO, 2016a). This could also include exemplars of models that are already working well.

Championing the development and use of technology could revolutionise the prevention and management of LTCs and the HWB of older adults (Dicianno et al., 2015). Policies that enhance the capacity to leverage their use including support in obtaining the resources and skills to implement, as well as

consideration of regulation and data security, would promote this further (Malvey and Slovensky, 2017).

Having the capacity to continually learn and develop will be essential for the global workforce in the dynamic healthcare environment (WHO, 2016b). In England, though, funding for professional development was reduced from £205m in 2015 to little more than £83m in 2017 for nurses and health professionals (Swan, 2018). Although Health Education England has announced an increase in 2018 of 17% compared to last year, more needs to be done to ensure its sustainability (Swan, 2018). This includes policies that provide incentives to healthcare providers that support the training of their workforce.

Healthcare policy globally, nationally and locally, needs to be realistic and attainable to be endorsed by the people who need to engage with it (Masic, 2018). Therefore, more consultation on policy initiatives is required so that those that will be affected by them can help to shape what takes place, namely, workforce, patients and the public. It will also foster more ownership and accountability to undertake the necessary changes to support its success.

All these policy initiatives will help to support the achievement of the United Nations sustainability goal to reduce premature mortality from NCD by one third (WHO, 2017a). At a recent United Nations meeting, World Leaders reaffirmed their commitment to realising this through the implementation of strategies to strengthen healthcare systems and the workforce (UN, 2018). Thus, the attainment of the SDG is still seen as a key priority, globally.

6.5 FURTHER RESEARCH AND FUTURE RECOMMENDATIONS

Additional research that I have undertaken includes an evaluation of the 'Men in Sheds' (MiS) programmes commissioned by Age UK. MiS initiatives aim to foster the building of social networks between older men by providing social space for them to meet and undertake activities such as woodwork or metalwork (Misan and Hopkins, 2017). This research incorporated a mixed-methods approach comprising interviews of men who attended the sheds and their family members, and focus groups with shed co-ordinators and community partners. My role was to investigate the impact of MiS on physical health and mental wellbeing by undertaking two self-reported surveys with the attendees: the SF-36, an indicator of overall health status, and the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), which reports mental well-being. The men undertook these at baseline and then 6 months later. Initial findings from the interviews identified the benefits for improving men's HWB with the social support that men gained from their peers being particularly key (Fisher et al., 2018) (see appendix 8.3.2). This is significant as, compared to women, men are less inclined to develop social connections that support their HWB or undertake health promotion initiatives (Milligan et al., 2016). Therefore, providing access to community enterprises, such as these, can help to improve health equity besides offering an opportunity to incorporate other health promotional strategies, for example, education on health issues. However, interestingly, there was no significant improvement in the self-report outcome measures and there was even a reduction in mental wellbeing and role limitations due to emotional problems (Fisher et al., 2018). Although this is an important consideration that needs to be investigated further, this could also demonstrate

the complexity of measuring HWB with outcome measures whose conceptualisation of HWB have already been pre-determined (Dodge et al., 2012). Further research in collaboration with older adults and people with LTCs to evaluate the appropriateness of measures for capturing their HWB experiences could, therefore, enhance their effectiveness (Lindert et al., 2015). It was also noteworthy that most men who attended the sheds were of White British origin. Additional research in collaboration with BAME groups to consider cultural adaptations to the Sheds could make them more desirable to diverse groups of older men, and, thus, help to improve the inclusivity of these groups of older men and, hence, health equity. This can also include consideration of how to access other hard to reach groups who are not accessing available resources that could support their HWB, for example, people who are socially isolated or homeless (Richmond Group, 2014).

Drawing on the findings from the focus groups carried out with students and academics (Hartley and Yeowell, 2017), I have been undertaking interviews with qualified physiotherapists to gain further insights into the perceived role of the physiotherapist. Enhancing understanding in this way will help to obtain more awareness of common grounding or differences between the different stakeholders and could help provide a starting point for an open discussion amongst the profession. The intention is to develop this research further by undertaking a national survey of physiotherapy clinicians. Questions will be developed from my findings from the focus groups and interviews to ascertain if there is any consensus of the views of physiotherapists about their future role and the perceived changes to be made.

To foster more multi-sectoral partnerships, more research needs to be undertaken to measure the cost-effectiveness of such collaborations for promoting the HWB of older adults and people with LTCs as this will influence commissioners' decision-making (Anderson et al., 2017). This needs to include practical ways to measure social impact, as this is the main priority of voluntary groups and organisations and social enterprises. It would also seem essential for demonstrating the efficacy of interventions focused on supporting population health and social determinants.

6.6 CONCLUSION

Promoting the HWB of older adults and people with LTCs can lead to more empowered individuals who have emotional resilience and the capacity to realise their full potential. However, for everyone to take part in this journey, it needs to be a collective endeavour where equal opportunities are provided for all. Creating environments that cultivate multi-sectoral partnerships and the sharing of community resources to foster the optimisation of HWB for everybody is therefore key. By promoting HWB in this way, rather than becoming the global burden that is predicted, many older adults and people with LTCs can be supported to flourish and continue to make a valuable contribution to their community.

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8 APPENDIX

8.1 NMC Questionnaire

A survey to explore clients' perceptions of physiotherapy at the NMC

1. Are you currently receiving physiotherapy at the NMC?
   (please tick) Yes☐ No☐

If "no" There is no need to complete any further questions. Please return the questionnaire to us in the envelope provided. Thank you for your time.

2. Please complete the following details:
   i) Are you Male / Female (*please tick*)

   How old are you? _____ years

   ii) Do you know the name of the neuromuscular disorder you have been diagnosed with? *(please tick)* Yes☐ No☐

   If "yes", what is the name of your neuromuscular disorder?_____

   iii) How long is it since you were diagnosed with your neuromuscular disorder?

   _____

   iv) On a typical day, can you complete **most** daily activities (e.g. washing, dressing, making a hot drink and shopping? *please tick*)

   With no assistance ☐ with some assistance for some tasks ☐
   With assistance for all tasks ☐ not able to complete most tasks ☐

3. How often do you attend for physiotherapy (*please tick one only*)?

   Twice a week or more ☐ Once a week ☐ once a fortnight ☐
   Once a month ☐ Less than once a month ☐

4. Do you think this is (*please tick*)?

   An appropriate length of time ☐ too much time ☐
   too little time ☐
   If too much or too little please state why you think this?

5. Who decides how often you attend physiotherapy at the NMC? (*please tick*)

   The physiotherapist ☐ you ☐

   anyone else ☐ (please state) _____

   Please state if there are any factors that affect how often you can attend for physiotherapy *e.g. work commitments*

6. On average how long does each physiotherapy treatment session last (*please tick*)?

   Less than 20 mins ☐ 20 to 40 mins ☐

   More than 40 mins but less than an hour ☐ An hour or more ☐ It varies ☐

7. Do you think this is (*please tick*)?

   An appropriate length of time ☐ Too much time ☐

   Too little time ☐

   If too much or too little please state why you think this is?

8. How long have you been having physiotherapy at the NMC (*please tick*)?

   For five years or more ☐
   More than a year but less than 5 years ☐
   Between 6 months and one year ☐
   More than 3 months but less than 6 months ☐
   Between 1 month and 3 months ☐
   Less than 1 month ☐

9. Other than the NMC have you attended for physiotherapy anywhere else?
   Yes☐ No☐

If **no**, please go to question 10

If **yes**, was it any different to your current physiotherapy at NMC?
Yes☐ No☐

If **yes**, please tell us how it was different in the space below:

10. Please list up to 3 reasons why you attend physiotherapy at the NMC.

    1.

    2.

    3.

11. Do you have any goals which you have set with the physiotherapist at the NMC?
    Yes ☐ No☐

    If **no**, please go to question 12

    If **yes**, please list them:

12. From your experience, how would you describe the role of the physiotherapist at the NMC?

13. Overall, are you satisfied with the level of physiotherapy provision you have received at the NMC? Yes☐ No☐

    If **no**, please tell us what you would like to be changed. If **yes**, please tell us what you think is good about it.

Thank you for taking the time to complete this questionnaire.

Please enter your unique identifier here:_____

This is to allow you to identify your questionnaire. It can be numbers and/or letters. You should keep a note of this code and only share it with the investigator should you wish to withdraw.

Please return the questionnaire to us in the envelope provided

8.2 Wellbeing Service Questionnaire

A survey to investigate service users' perceptions of a Wellbeing Service for people with psychological and emotional distress.

1. How did you become aware of the wellbeing service? (*please choose one only*)

   By your GP ☐ Advert ☐ Recommendation from a service user ☐ Other ☐
   (please specify) _____

2. What was the main reason why you attended this service?

3. How often did you attend the wellbeing service? (*please tick one only*)

   Daily ☐ Once a week ☐ Once a fortnight ☐
   Once a month ☐ Less than once a month ☐

4. Do you think this was? (*please tick one only*)

   An appropriate length of time ☐ Too much time ☐ Too little time ☐

   If too much or too little time, please state why you think this?

5. Please state if there are any factors that affected how often you could attend *e.g. work commitments*

6.

   Very satisfied ☐ Satisfied ☐ Unsatisfied ☐ Very unsatisfied ☐

If you were not satisfied by the therapy offered, please can you comment as to why?

7. Have you accessed any other activity or service in the community that you were made aware of by the wellbeing worker? Yes ☐ No ☐

   If no, please can you comment on why not and then go to Q 8

   If yes, what was this activity or service?

   _____

   _____

   Please comment on your experience of attending this activity or service and how it affected your wellbeing

8. How long did you have to wait for an appointment to see the wellbeing worker (please specify) _____

9. Has attending the service changed any of the following and if so, in what way?

	Yes or No	**If yes, in what way?**
Your connections and relationships with others		
Your level of physical activity		
Your ability to appreciate everyday moments		
Activities you have undertaken or new learning experiences		
Your ability to help others and feel good about it		
Your employment status		

10. When you first attended the service, did you experience any physical pain that was affecting your mood? Yes ☐ No ☐

    If yes, do you feel that attending the service helped you to live well in spite of pain? To a great extent ☐ Somewhat ☐ Very little ☐ Not at all ☐

11. How much do you agree or disagree with the following statements about your wellbeing worker?

	Strongly agree	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
Had the skills to provide appropriate psychological support					
Had a good understanding of my circumstances					
Was empathetic					
Included me in making decisions about my therapy					
Was focused on my own individual needs					

12. Overall, how satisfied were you with the service the wellbeing workers provided?
    Very satisfied ☐ Satisfied ☐ Unsatisfied ☐ Very unsatisfied ☐

13. Do you feel that accessing the wellbeing service has helped you?
    To a great extent ☐ Somewhat ☐ Very little ☐ Not at all ☐

    Please comment on what was helpful or unhelpful for you?

14. Are you likely to recommend this service to anyone else?
    Definitely ☐ Probably ☐ Maybe ☐ Probably not ☐ Definitely not ☐

15. Do you have any other suggestions on how the wellbeing service could be improved?

Thank you for taking the time to complete this questionnaire.

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8.3 Further Research

8.3.1 Abstract for the WCPT Congress in South Africa.

Hartley, S. and Yeowell, G. (2017) 'Future proofing the Physiotherapy Profession'. Research presentation at: *World Confederation for Physical Therapists (WCPT) Congress*. Cape Town, South Africa, 02 July 2017 - 04 July.

World Confederation for Physical Therapy
World Confederation for Physical Therapy CONGRESS 2017 Cape Town

Future proofing the Physiotherapy Profession

Authors: Sandra Hartley and Gillian Yeowell

Background

The augmentation of chronic conditions due to an ageing society, the lack of physical activity and the pursuit of unhealthy lifestyles, poses a major challenge to global health care systems. Furthermore, the costs of health care, due to co-morbidities, are continuing to escalate. Therefore, innovative ways to provide cost effective services are needed. As modifiable risk factors account for over half the disease burden of later life, interventions targeted at the population level by promoting public health and wellbeing, could make a significant contribution to the prevention of chronic diseases and their progression. The physiotherapy profession is ideally placed to take on initiatives that lead the way in revolutionising the management of chronic conditions.

Purpose

To explore the role of the physiotherapist as viewed by physiotherapy academics and undergraduate physiotherapy students. The intention is to gain an insight into the future scope of the physiotherapy profession.

Methods

The study followed an exploratory qualitative design, undertaken from an interpretive paradigm. A purposive sample was used to recruit participants to two focus groups, one with academic staff and the other with 3rd year BSc

(Hons) undergraduate physiotherapy students. All participants were recruited from a university in England in 2016. Both focus groups were carried out by the same researcher (SH). Each focus group interview lasted 50-70 minutes and was digitally recorded. An interview schedule was used to guide the interviews. Interview data were transcribed verbatim and analysed using thematic analysis.

Results

Six academics were recruited for the first focus group; four were female. Their experience of working in academia ranged from 2 to 24 years. Seven students were recruited to the second focus group; five were female. Three themes were identified and were common to both groups: ‘philosophy of practice’, ‘changing role’, ‘tension between cultures’.

Conclusion

An underpinning philosophy of practice that promotes holistic care and supports patient wellbeing is perceived to dictate the role of the physiotherapist. As well as the attainment of core competences, transferable skills are deemed important to ensure this is accomplished. There is an awareness of the changing role of the physiotherapist including an extended role and a more public health focus, with the need to consider the cost implications of care. Although it is perceived that physiotherapists have a voice, their role is influenced by changes in the health service, which is shaped by government’s ideology. Role mismatch between the university and practice and the demands of the market place, provide tensions within the profession. The next stage is to consider physiotherapists’ viewpoint of their future role.

Implications

Physiotherapists could lead the way in revolutionising the management of chronic condition. Only by reflecting on their role within the changing face of healthcare, can a clear vision for the future be created that ensures physiotherapists remain fit for practice. However, there are many tensions to be confronted. Rising to these challenges requires a shared endeavour across the physiotherapy profession for radical change in practice including, the capacity to take on the role of public health promoters.

Keywords
chronic conditions, public health, service provision

8.3.2 Men in Sheds Report for Age UK

Fisher, J., Lawthom, R., Hartley, S., Koivunen, E. and Yeowell, G. (2018) *Evaluation of Men in Sheds for Age UK Cheshire. Final Report July 2018.* Manchester: Centre for Psychology, Health and Community, Manchester Metropolitan University.

Accessible from the following link:

https://e-space.mmu.ac.uk/.../Evaluation%/